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Individual Program Planning

for developmentally handicapped people

Proposed Standards and Guidelines

Program Development Series
Volume III

42 V

INDIVIDUAL PROGRAM PLANNING FOR DEVELOPMENTALLY HANDICAPPED PEOPLE: PROPOSED STANDARDS AND GUIDELINES

Ministry of Community
and Social Services

March, 1983

PROGRAM DEVELOPMENT SERIES

Volume I	Directory of Assessment Services for Developmentally Handicapped People	March 1983
Volume II	Functional Assessment Instruments for Developmentally Handicapped People	March 1983
Volume III	Individual Program Planning for Developmentally Handicapped People: Proposed Standards and Guidelines	March 1983
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Policy and Program Development Division
Ministry of Community
and Social Services

PREFACE

This paper presents for consultation with service agencies and providers and with other interested people a set of proposed standards and guidelines for individual program planning for developmentally handicapped people. Previous policy papers have expressed the Ministry's commitment to individual program planning. The need for standards in this area was identified in the report of the Task Force on Individual Program Planning, a body with representation from both the Ontario Association for the Mentally Retarded and the Ministry. The standards and guidelines included represent generally accepted practices based on the experience of the last decade both in Ontario and elsewhere.

The paper contains standards and guidelines for assessment of the needs of developmentally handicapped children and adults, for the individual program planning process and for the maintenance of related records. It proposes the participation of developmentally handicapped people and their families in the development, implementation and review of their individual program plans. It should, therefore, be of interest to parents as well as staff of service-providing agencies and other professionals and groups working with handicapped people. The Ministry hopes that it will serve as an educational tool, and stimulate extensive discussion among all those who share a concern with the quality of service to developmentally handicapped and with strengthening current practice.

The proposed standards when finalized will be directed towards Ministry-funded facilities and services operated under:

- the Homes for Retarded Persons Act
- the Developmental Services Act
- the Vocational Rehabilitation Services Act.

Compliance with the proposed standards would be enforced through an inspection process provided for in the regulations pertaining to the approval or funding of these facilities and services.

Individual program planning standards for programs serving handicapped children operated and licensed under the Day Nurseries Act were proposed in another Ministry consultation paper, Day Nurseries Services: Proposed Standards and Guidelines, released in 1980. Revised following consultation, the final standards for those services are contained in the new Ministry publication, A Policy Statement on Standards for Day Nurseries.

The Ministry wishes to thank all those involved in the development of the proposed standards and guidelines for giving so generously of their time, knowledge and experience.

Participants in the Development of the Standards and Guidelines

The Task Force on Individual Program Planning

Eden Anderson	-	(Chairperson) Senior Policy Analyst, Policy and Program Development Division Ministry of Community and Social Services
William Chapman	-	Assistant Administrator, Community and Development Services Adult Occupational Centre, Edgar
Jeff Earle	-	Senior Program Director, Rideau Regional Centre
John Hull	-	Manager, Developmentally Handicapped Unit Policy and Program Development Division Ministry of Community and Social Services
Mary Kovacs	-	Consultant
Faith Mills	-	Program Supervisor, Children's Operations, Toronto Area Office
Cheryl O'Connor	-	Program Supervisor, Adults' Operations, Kingston Area Office
Anne Stafford	-	Director Community Living Ontario Association for the Mentally Retarded

Ministry Steering Committee:

Eden Anderson	-	(Chairperson) Senior Policy Analyst
Michelle Farrell	-	Research Analyst, Research and Evaluation
John Hull	-	Manager, Developmentally Handicapped Unit
Mary Kovacs	-	Consultant
Maxine Walsh	-	Consultant M.R. Services Unit, Operational Support Branch

Consultants:

Abt Associates of Canada

Christine Wihak - Research Consultant
Sue Corlett - Senior Research Consultant
with advice from external consultants:
Eric Haughton
Karen Green
Ruth Freedman

A.R.A. Consultants

Diane Galambos - Developmental Program Consultant and Coordinator, Developmental Care for the Mentally Retarded, Sheridan College

Linda Reid - Partner, A.R.A. Consultants

Patti Wilson - Residential Services Director, North Halton Association for the Mentally Retarded

Mary Chase - Formerly Senior Consultant, A.R.A. Consultants

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INDIVIDUAL PROGRAM PLANNING
FOR DEVELOPMENTALLY HANDICAPPED PEOPLE:
PROPOSED STANDARDS AND GUIDELINES

1. PLANNING FOR DEVELOPMENTALLY HANDICAPPED PEOPLE

The proposed standards and guidelines for individual program planning for developmentally handicapped people reflect the Ministry's commitment to ensuring well planned and implemented service to all clients of Ministry-funded programs. This chapter of the consultation paper describes current Ministry policy on service to developmentally handicapped people and Ministry involvement in the establishment of service standards in sections that discuss:

- o individual program planning and its significance
- o Ministry efforts to plan for developmentally handicapped people
- o the significance of standards in achieving adequate service
- o the approach taken to developing the standards and guidelines for individual program planning.
- o related standards development activity.

Individual Program Planning

The individual program plan is a written plan for action outlining steps to meet personalized goals for a developmentally handicapped person. It is developed and implemented by a team including the individual and the individual's family, as appropriate, and based on a thorough assessment that reflects a holistic view of the individual. The plan states overall goals and specific objectives, and method, responsibilities and target dates for implementation. These are reviewed frequently to determine the individual's progress, and ensure their appropriateness.

The individual program planning approach to service is founded on principles, discussed in detail in the following chapter, that assume that all people have the potential for lifelong development and growth. The intent of the approach is to maximize the developmentally handicapped person's potential for achieving self-sufficiency in the community. The process of individual program planning systematically involves the handicapped person and family members along with key service providers in:

- o assessing the handicapped individual's needs
- o formulating functional goals and objectives, and setting these out in a written individual program plan
- o carrying out planned programs of service and support
- o evaluating ongoing progress and overall program success, and revising the plan.

Individual program planning departs from previous service approaches in significant ways. It involves the handicapped person in decision making, which respects the individual's judgement, and should result in the selection of relevant goals. In addition, the handicapped person may take responsibility for seeing that certain aspects of these goals are met. Also, the individual program plan is prepared in written form and all parties must agree to it. The plan establishes agreement as to individual responsibilities. It ensures relevant and focussed communication among staff members, promotes rationality and precision in the planning and implementation of programs, and provides direction and guidance for the efficient use of resources. The plan ensures continuity and consistency of programming, and provides a lasting framework within which the effectiveness of a program can be judged.

Ministry Planning Initiatives

In 1973, the Government of Ontario adopted a new policy focus for the delivery of services to developmentally handicapped people. Developed in response to reports titled Present Arrangements for the Care and Supervision of Mentally Retarded People in Ontario* and Community Living for the Mentally Retarded in Ontario,** the new policy emphasized expansion of community living opportunities and the development of alternatives to institutional care.

In keeping with the new focus, responsibility for services to developmentally handicapped people was transferred from the Ministry of Health to the Ministry of Community and Social Services in 1974. The Ministry five-year implementation plan approved in 1975 included detailed proposals for the development of community-based accommodation, training and support services, and proposed that an individual program plan be developed for every client of Ministry-funded services for developmentally handicapped people.

Services in the community for developmentally handicapped people have expanded dramatically in recent years, and considerable effort has been devoted to implementing the individual program planning approach in Ministry-funded services. Individual program planning has increasingly been emphasized as a means of assisting clients to achieve more independent living, for example by moving from institutions to community programs.

Implementation of effective individual program plans has, however, proved more complex than originally anticipated. The Task Force on Individual Program Planning, which was established in 1980 and reported in 1981, noted a number of problems including a wide variation in interpretation of the individual program planning concept, assessments that were not used effectively in programming for clients, a lack of training for personnel and poor service coordination.

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* Williston, Walter, Present Arrangements for the Care and Supervision of Mentally Retarded Persons in Ontario, Ontario Department of Health, 1971.

** Welch, The Hon. Robert, Community Living for the Mentally Retarded: A New Policy Focus, Provincial Secretary for Social Development, 1973.

The recommendations of the Task Force resulted in the undertaking of four projects:

1. Assessments for developmentally handicapped individuals: This project focussed on assessment services and instruments for individual program planning purposes and included:

   - a provincial survey of assessment services
   - compiling of data on assessment instruments
   - drafting of the standards and guidelines for assessments, which form part of this paper on individual program planning standards.

2. Staff training in individual program planning: This project produced the design for a provincial staff training program. It is intended to assist personnel in the field of mental retardation to improve their skills in developing and implementing individual program plans and is scheduled to begin in 1983.

3. Case management in services for developmentally handicapped people: The intent of this project was to establish a more effective means of coordinating services to individuals and providing case management services where necessary.

4. Standards and guidelines for individual program planning and record keeping: This project involved the development of the proposed standards in this paper, which provide the basis for standardizing the quality of individual program planning.

The Function of Standards

As both a direct provider of services and a funder of other service providers, the provincial Government is ultimately accountable to the public for the ways in which public monies are expended on services and for the quality of the services provided. In the view of the Ministry, standards are essential to ensuring the adequacy of service and the accountability of the service providers.

Accountability on the part of either an individual or an organization implies not only the liability, but also the capacity, to be held to account for the performance of a given responsibility. Standards, as defined by the Ministry, specify the criteria against which the performance of persons, agencies or programs will be measured, and thus provide the basis for holding them accountable for their performance.

Standards, as so defined, must be expressed in precise, measurable terms. To have meaning as accountability measures, standards must be derived from the best existing knowledge and based on agreed-upon definitions and measurements, and they must be enforceable and enforced.

The standards currently being developed for Ministry-operated and funded services define clearly and consistently the Ministry's expectations concerning the minimum acceptable quality of service. They address:

- the need for clearly defined descriptions of programs, and for consistency and congruence of the activities undertaken to deliver these programs
- a necessary minimum state or level of performance.

Ministry-operated programs as well as programs licensed or approved by the Ministry are required to comply with the standards.

The standards require that activities the Ministry believes essential to ensuring the protection and well-being of program clients, and accountability, are carried out. There is no intention to dictate organizational practices. It is expected that requiring operators to develop stated policies and procedures and to introduce certain functions where these have not existed will yield the following benefits:

- better programming to meet clients' needs
- protection for staff in the performance of their responsibilities
- more efficient operation and use of both internal and external resources.

The guidelines being developed as part of the Ministry's standard setting process contain less rigorously measurable provisions than the standards, and are intended to serve different and more varied purposes. Their primary purpose is to set out preferred levels of performance that services can use for self-assessment. Unlike the standards, the guidelines will not be used as the basis of a service review, and lack of adherence to the guidelines will not result in loss of Ministry approval.

Guidelines will also serve as a basis for consultative and developmental relationships between service providers, Ministry field staff, clients and their parents or guardians and/or advocates. Many aspects of the quality of care are not easily regulated. Greater benefit is likely to be achieved in these areas through consultation and developmental activities than regulation.

The Approach Taken to Development of the Standards and Guidelines

Means of implementing individual program planning have been under consideration for several years. A discussion paper on individual program planning that was circulated within the Ministry in 1980 generated considerable positive feedback from Regional and Area Offices, many of which

held consultation meetings with service providers in the mental retardation field to discuss the policy direction proposed in the paper. This initiative was followed by the establishment of the task force with representation from both the Ontario Association for the Mentally Retarded and the Ministry that recommended the development of standards and guidelines as one means of implementing a consistent and comprehensive approach to individual program planning. Following Ministry approval of the task force's recommendation, the consulting firms Abt Associates of Canada and A.R.A. Consultants drafted the standards and guidelines with the assistance of a Ministry steering committee. The draft material was given further internal Ministry review to ensure that the approach and content were consistent with those of the other standards and guidelines developed by the Ministry in recent years.

In developing the proposed standards, consideration was given to the appropriateness of the proposed requirements, the practicability of implementation and the feasibility of enforcement. Standards are basically of two kinds: content standards and process standards. A requirement that there be an individual program plan is a content standard. Requirements that the plan be developed and implemented in certain ways are process standards. Determining compliance with content standards is usually straightforward in that the component is either present or absent. It is difficult to develop process standards, because they deal with the manner of service delivery and with interactions among service providers and clients. It is also difficult to monitor and enforce compliance with process standards because of the element of judgement involved in determining whether a requirement has been met. Most of the proposals deal with the process of individual program planning. It is expected that consultation will help determine which of the proposals should be standards and which should be guidelines when the final standards are prepared for implementation.

It should be noted as well that the guidelines proposed in this paper are of two kinds. Those that accompany the proposed standards for the individual program planning process are directed to the team involved, and suggest ways in which the standards may be met. Other guidelines are intended as support to this process, and are directed not only to agencies responsible for individual program plans but also to the agencies providing the assessments that are key elements in the process.

Standards Development in Other Areas

Several sets of standards and guidelines have been developed by the Ministry in addition to those proposed for individual program planning. The areas covered include:

- Children's residential care facilities: Proposed standards recognizing the similarity of the basic needs of all children and designed to apply to all residential settings for children within the Ministry's jurisdiction were revised following public consultation and incorporated into regulations under the Children's Residential Services Act. The final standards are those the Ministry considered essential to ensuring the protection and well-being of the children in care and adequate monitoring of the service provided. They include a requirement for the development of an individualized plan of care for each child.

- Day nurseries: A consultation paper containing proposals intended to clarify, simplify and, where possible, reduce existing day nurseries regulations, while extending coverage to private-home day care under agency supervision. The paper proposed individual program planning standards for services for developmentally and physically handicapped children. The revised and final standards are contained in the Ministry publication, A Policy Statement on Standards for Day Nurseries, and will be incorporated into regulations under the Day Nurseries Act.

- Foster care: Another consultation paper proposed standards and guidelines for foster care. It discusses the special requirements for foster care of children with developmental and physical handicaps and severe behavioural and emotional disorders, and proposes guidelines in this area. The final standards will be revised as appropriate and incorporated into a separate set of regulations under the Children's Residential Services Act that will govern the licensing of placement agencies.

- Child abuse: The Standards and Guidelines for the Management of Child Abuse Cases Under the Child Welfare Act, 1978 by the Children's Aid Societies are designed to make the investigation and case management of child abuse cases as uniform as possible throughout the province.

2. THE PHILOSOPHY BEHIND INDIVIDUAL PROGRAM PLANNING

Standard Setting Goal

The goal in setting standards for individual program planning is to ensure that developmentally handicapped people in programs funded by the Ministry of Community and Social Services receive the opportunity to develop their physical, intellectual, social, and emotional capabilities to the fullest extent possible. Improved individual program planning aims at assisting developmentally handicapped people to acquire the skills, habits and attitudes essential to living in present-day society.

Principles

The following principles have guided the development of the standards and guidelines for individual program planning for the developmentally handicapped.

1. Normalization: Programs should reflect the conditions and support the patterns of behaviour that are characteristic of everyday community life.

2. Developmental Model: Programs should provide a systematic framework for positive change based on the assumption that all persons are capable of growth, development and learning.

3. Client Participation in Decision Making: Programs should provide for the active participation, to the fullest extent possible, of the client and, as appropriate, of the client's family or guardian and/or advocate in the service provided.

4. Accountability: Service providers should be accountable to the consumers of service and to the public or funding body that supports it for the achievement of the stated goals of the service.

5. Evaluation: Service providers should regularly assess the effectiveness, appropriateness and efficiency of their programs, communicate the results of the evaluation to those responsible, and revise the programs accordingly.

The implications of these principles for individual program planning are discussed below.

Normalization

Normalization has been defined as the "use of culturally normative means" to offer developmentally handicapped persons "life conditions at least as good as (those) of average citizens and to as much as possible enhance or support their behaviour, appearances, experiences, status and reputation".(1) All individual program planning practices and procedures for the developmentally handicapped should reflect consideration of the normalization principle, to help establish patterns and conditions of everyday life that are as close as possible to the regular circumstances and ways of society.

As elaborated by Bengt Nirje,(2) this implies normal patterns in all activities:

- daily routines for getting up and getting dressed, involvement in meaningful activities, eating and retiring in normal circumstances
- weekly routines with the differentiated settings, schedules and activities of home, school/work and leisure
- the observance of annual holidays, days of personal significance and vacations
- normal experiences of the life cycle that progress from early childhood through school age and adulthood to old age
- respect and consideration for the wishes and choices of the person as well as his or her right to self-determination
- life in a social world that includes friendships, dating and marriage
- normal economic standards through access to financial assistance and sheltered or competitive employment
- environments where all activities are modelled on those available to the mainstream of society.

Restoration and/or maintenance of a valued social status for developmentally handicapped persons are central to the process of normalization. Developmentally handicapped persons whose place in society is valued and integrated will experience activities that are appropriate to their age and culture, that protect their personal integrity while allowing them the dignity of risk that accompanies normal living.

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1. Wolfensberger, 1980.
2. Nirje, 1980.

The anticipated effect of normalization is not to make handicapped people "normal"; rather, it is to improve the quality of their lives. When properly implemented, normalization positively affects developmentally handicapped persons' quality of life, not as a "treatment" given them, but as a foundation for planning, delivering and evaluating human services.

A corollary of normalization is the desirability of meeting the individual's developmental and service needs through the most integrative service alternative. Integration occurs at several levels: physical, functional, personal, social, societal, and organizational. Where the available alternatives are restrictive, efforts should be made to develop and/or support more integrative alternatives.

The Developmental Model

Program models in human services are characterized by distinctly different perspectives on overall program goals, the role of the recipient of service and the nature of his or her relationships. The models are reflected in functional philosophy, methods and terminology used, physical and administrative structures, and job descriptions.

The developmental model provides the most desirable framework or set of ideas to support programs for developmentally handicapped persons. It assumes that all persons are capable of growth, development and learning, and suggests a positive interpretation of developmental handicaps and programming.

- Every handicapped person is considered to have some potential for development, and efforts to maximize the person's potential should not be abandoned although progress may be limited.
- The handicap is viewed as functional, and a medical condition, though perhaps a contributing factor, as of secondary concern.
- Functional assessment is favoured over diagnostic assessment as the basis for programming.
- The helping relationship is one of consulting, training and teaching aimed at fostering self-reliance and maximizing potential.
- Residential services are patterned on and aimed at normal life experiences.(3)

This program model is based on three core concepts:

1. Change as a characteristic of life: From the moment of conception, the most outstanding characteristic of life is that it changes, both physiologically and psychologically, and continues to do so throughout the life span of every human being.

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3. See Roos, 1971.

2. Movement from simple to complex skills: The life long change characteristic of all human beings progresses in a predictable, orderly sequence that can be identified, and is seen as moving onward from simple skills that become the foundation for more complex skills or behaviours.

3. Individual rate of development: Movement through developmental sequences is variable, influenced by individual and cultural differences. The rate and direction of an individual's development may be significantly altered by manipulating physical and psycho-social variables in the environment. The potential for development is realized in an environment that provides suitable opportunity and support.

Thus the developmental model suggests that developmentally handicapped persons are more "like" than "unlike" non-handicapped persons, and rejects the notion that differences are qualitative.(4)

Although the developmental model holds positive programmatic implications, it is susceptible to misuse or misinterpretation. Developmental "model" is sometimes equated with "sequence", resulting in possible negative effects for the handicapped individual.

Sequences of development are not inviolable, as witnessed by the variability in any random group of children. The rate of progress through a sequence varies among children and even for the individual child. There can be a tendency, however, to use sequences in a developmental assessment or curriculum in a lockstep or rigid and simplistic fashion.

Decisions regarding program goals ought to be governed by the developmental model, not the developmental sequence. The developmental model prescribes goals that influence the rate and direction of change. The criteria used in selecting the rate and direction of change ought to be derived from those aspects of human living that are most valued and adaptive. The decision-making process should encompass the following broad goals:

1. Increased ability to cope with the environment: Coping implies the ability to have some control, for example by making choices. Control begins with having input into decisions made about one's life, and extends to learning specific skills in and for specific environments. Change should be in the direction of skills that are age-appropriate and needed for success, as defined by current and future roles and cultural expectations.

2. Increased complexity of behaviour: Effective adaptation to a complex environment requires complex patterns of behaviour, which emerge from the integration of more simple abilities and activities. Prerequisite skills for more advanced behaviour must be taught in an environment that supports and provides opportunities for the inter-relation of ideas, emotions and skills.

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4. Ziegler, 1969.

3. Maximization of human qualities: The maximization of human qualities that are valued becomes perhaps the most basic criterion for choosing program goals. Human qualities are those attributes that describe the essential nature of man, and include loving, curiosity, spontaneity, initiative and enthusiasm.

Developmental programming will be characterized by the expectation of positive change, individualization and positive, helping relationships in an appropriate environment and grouping. The developmental goals for handicapped and non-handicapped persons are essentially the same.

Client Participation in Decision Making

Incorporating the principle of client participation into the individual program plan for a developmentally handicapped person respects that person's individual worth, and acknowledges the good judgement of the client and family/advocate with regard to determining the client's needs and how they may best be met. Implementation of this principle is also a means of increasing developmentally handicapped persons' ability to assume the maximum possible control over and responsibility for decisions and events in their own lives. The principle stresses their strengths in terms of what they can do for themselves. Also, direct involvement in the planning and carrying out of the individual program plan enables the client to better understand the expectations and to see the effects of the plan.

In this approach, client, family and staff have a shared understanding of and sense of responsibility for the program, and participate as equal members of a team. The key decision points in the individual program planning process that call for client/family/guardian/advocate participation include:

- o assessment of strengths and areas where development and positive change are possible and desirable
- o specification and priorization of goals and methods
- o review of progress
- o modification or termination of the plan.

As this decision-making process proceeds, it is essential that clients, and/or their family/guardian/advocate, participate as much as possible in planning their own program, and that they have access to all information regarding this planning, as a basis for responsible decision making. Clients have the right to retain control over their own lives and the right to full information regarding decisions concerning them.

The capacity of developmentally handicapped people to speak on their own behalf varies, depending on their level of functioning. Some will be able to participate in discussions with some explanation of and assistance in keeping to a topic under consideration, while others will be completely non-verbal. A client who cannot fully or clearly represent his or her own views needs a parent, advocate or service provider to speak on his or her behalf. This person must be able to empathize with, communicate with, and elicit responses from the client whenever possible. Whatever the client's communicative ability, his or her presence will provide a needed focus for the other team members, and should ensure attention to his or her interests and preferences.

Accountability and Evaluation

It flows from the principles of accountability and evaluation in human services funded by public resources that:

- The Ministry is charged with the stewardship of public resources, and is accountable to those on whose behalf the resources are expended (i.e. the public).
- The organizations to which authority and responsibility are delegated understand and accept the delegation.
- Those delegating and those receiving the authority and responsibility have a clear understanding of the criteria by which those exercising the delegated authority and responsibility will be judged.
- Clearly defined processes and procedures exist for measuring and evaluating the results of the exercise of delegated authority and responsibility and for communicating the evaluation.

Ensuring accountability for delegated responsibilities requires a mechanism for regular, formal monitoring and adherence to established performance standards. A clearly specified individual program plan provides the basis for measuring the extent to which a given service provider, a service agency or a service system is delivering service to individual clients in accordance with delegated authority and responsibility.

3. MONITORING COMPLIANCE WITH THE PROPOSALS

Following consultation on the proposals in this paper, the Ministry will review the feedback received to determine whether and what changes should be made in the proposed standards, and revise them accordingly. The final standards will be used to review and monitor an agency's performance in planning for developmentally handicapped people.

The proposed approach to approval of agency operations on the basis of compliance with the standards is as follows:

- Residences operated under the Homes for Retarded Persons Act would be approved for continued operation on the basis of compliance with the final standards, which will be incorporated into regulations under the Act. Regular and routine reviews would be carried out.

- Residences and agencies operated under the Developmental Services Act and the Vocational Rehabilitation Services Act would also be required to comply with the standards. Compliance with the standards would become part of the financial agreement between the Ministry and the agency. All agencies receiving funding would be required to comply with the final standards. Compliance with the standards would be reviewed when funding agreements are made. Compliance with the standards would not guarantee a program funding, but a program would not be funded unless it complied with them.

As indicated in Chapter 1, the guidelines are intended primarily to be used by agencies to assess their own performance against preferred levels of performance. Unlike the standards, the guidelines will not be used for monitoring purposes, and lack of adherence to the guidelines will not result in the loss of Ministry approval. A number of the proposed guidelines, expressed in measurable terms, suggest ways in which compliance with standards may be achieved. There may be other ways in which the standards could be met, and such guidelines should not be read as excluding alternative courses of action.

Five methods of monitoring compliance are under consideration:

- Self-assessment: The organization would monitor and review its own practices and procedures, and report to the Ministry whether it is in compliance with the standards.

- An auditing approach: The organization would provide Ministry-specified proof of compliance obtained through either internal or external audit.

- Team review: The Ministry would assign a group including Ministry representatives to monitor the organization. The reviews would probably include review of written plans and interviews with staff.

- Peer review: The Ministry would select a group of providers of similar service to monitor the organization. The reviews would probably include review of written plans and interviews with staff.

- Review by Ministry personnel: The Ministry would assign its own personnel, normally program supervisors, to monitor the organization. The reviews would probably include review of written plans and interviews with staff.

The Ministry may choose to use any one method or a combination of methods. For example, the Ministry could arrange for monitoring of services by its own staff every second year and for agency audits in intervening years. The Ministry will be seeking the views of the field on these methods of monitoring compliance during the consultation on the proposed standards. Cost, objectivity and technical competence will be the criteria for determining the method or methods to be used for monitoring compliance.

A process for appeal of compliance decisions would be available to residences and agencies. Provision would also be made for consideration of requests for exemption of a given agency from compliance with particular standards.

In preparation for the implementation of the individual program planning standards, the Ministry will be supporting training sessions that will cover both the concepts underlying individual program planning and the actual practice of developing and carrying out a plan. The training will be directed towards staff directly responsible for individual program planning. Further details and announcements about training will be available following the standards consultation process.

4. CONSULTATION ON THE PROPOSALS

The proposed standards and guidelines set out the practices and procedures believed to be necessary to ensure that every developmentally handicapped person has an individual program plan to develop his or her mental, physical and social functioning, and to help him or her to progress towards independence. They are expected to assist agencies with their performance in individual program planning. The Ministry asks operators of residences and workshops, parents and professionals caring for developmentally handicapped people to review the contents of this paper, to consider the appropriateness of the standards and guidelines proposed, and to suggest changes in them. The intent of consultation is to ensure that the final standards are essential and represent minimum levels of practice. As indicated elsewhere in this paper, a number of services are implementing individual program plans in various ways. The Ministry is aware that there are strong views in the field on individual program planning, and wishes to ensure that these views are heard and that good practice is recognized.

A short, tightly organized consultation for this purpose is planned. Staff members in residences and workshops, parents involved in associations for the mentally retarded and particularly those who will implement the proposed standards, including developmentally handicapped people themselves, are encouraged to participate. Meetings organized by Area Offices will be held in each region of the province to give all those interested an opportunity to ask questions about and discuss the proposals with Ministry staff. Invitations will be sent to representative groups and individuals, and public announcements of the times and locations of the discussion will be made well in advance of these sessions.

Written submissions outlining either general observations and concerns or detailed comments on the application of the proposed standards to particular programs are welcome. All briefs will be reviewed and a response prepared.

To obtain additional copies of the paper, write to:

Project Management and Implementation Planning Unit
Ministry of Community and Social Services
700 Bay Street
9th Floor
Toronto, Ontario, M7A 1E9.

Telephone: (416) 965-3130.

If you are submitting a written brief, please complete the "Response to Consultation Paper: Summary Sheet" that is on the last page of the paper. Your written response should be sent to:

Standards Development Unit
Corporate Planning Branch
Ministry of Community and Social Services
4th floor, Hepburn Block
80 Grosvenor Street
Queen's Park
Toronto, Ontario, M7A 1E9.

All briefs must be submitted by July 29, 1983

5. HOW TO READ THE STANDARDS AND GUIDELINES

The proposed standards and guidelines for individual program planning are presented in a uniform format with a numbering system intended to facilitate cross-referencing.

General Organization

The standards and guidelines are presented in Chapters 6 through 12. Standards and guidelines are proposed for:

- the team approach to individual program planning
- the components of the four-stage individual program planning process:
  - assessments for individual program planning
  - the individual program plan: development and content
  - implementation of the individual program plan
  - review of the individual program plan
- individual program planning records
- agency supports for individual program planning.

The standards and guidelines topics are divided into sub-topics, each of which is assigned a number. The sub-topic numbers run consecutively throughout the major topics. The assessment sub-topic numbers, for example, run consecutively from

- **A-01 Identifying Assessment Needs**

through

- **A-04 Synthesis, Reporting and Follow-up of Assessments.**

The standards and guidelines are assigned decimal numbers within each sub-topic. For example, Synthesis, Reporting and Follow-up of Assessments has two standards numbered AS-04.1 (S for standard) and AS-04.2 and two guidelines numbered AG-04.1 (G for guideline) through AG-04.3.

"Standards" and "Guidelines"

"Standards" are considered mandatory conditions for approval.

"Guidelines" describe desired levels of performance.

Note: To ensure that readers do not confuse standards and guidelines, the proposed standards will be shaded grey.

6. THE TEAM APPROACH TO INDIVIDUAL PROGRAM PLANNING

Individual program planning should be approached as a process in which the developmentally handicapped individual, his or her family[5] or advocate, an agency worker or workers and other relevant professionals participate as a team in the planning, delivery and review of a single, integrated individual program plan to meet the individual's identified needs. The collaboration of several people, each utilizing the skills, knowledge and perspectives provided by his or her training and experience, is considered to be the most effective means of assisting handicapped persons.

In addition to the handicapped individual, core team members comprise persons working most directly with the individual. These may include direct service staff, special consultants, the case manager or family support workers. Other persons may be added to this core at any time as needed. There is no standard composition of an individual program plan team. The membership of each team should be appropriate to the unique combination of needs of the handicapped person involved.

Team Membership

Commentary

The team approach to individual program planning requires the full and direct participation of the developmentally handicapped individual and/or the client's family or advocate. The standards require the participation of the developmentally handicapped person aged 16 or older and an invitation to attend to the handicapped young person aged 12 or older. This is consistent with the provisions in the standards for children's residential care facilities under Ministry jurisdiction, which require the development of an individual plan of care for each child with the involvement to the maximum extent possible of the child aged 12 or older. Team procedures must encourage and facilitate the participation of the client and/or the client's representative as informed team members.

Effective service delivery requires coordination of resources. Such coordination involves initiating, sustaining, and inter-relating the various parts of the service delivery system. In a variety of documents, the Ministry has identified the importance of case management in coordination of service delivery. It is currently developing a comprehensive policy on case management in children's services. A recent consultant report to the Ministry recommended that specialized case management services be provided to some developmentally handicapped clients by case managers who are independent of direct services.

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5. "Family" in this discussion is assumed to refer to the parents or guardian of a developmentally handicapped child. It may also include another family member who wishes to be involved in the individual program plan, particularly in the case of a developmentally handicapped adult.

To enhance consistency and efficiency in the individual program planning process, one team member must be responsible for overall coordination of the activities of the individual program plan team and for ensuring that plans are developed, implemented and reviewed as scheduled. This team member, referred to as the individual program plan coordinator, may be the client's case manager where there is such a person. The coordinator may also be another agency worker such as a residential counsellor, or a family support worker or public health nurse or other service provider working with the client and family, or a parent, other family member or other person closely involved with the individual, depending on the skills and qualifications of members of the team. The choice of which team member is to be the individual program plan coordinator will be unique to each setting and will require the cooperation of agencies involved with the client to determine the most logical person. The coordinator role may shift over time as the focus of the individual program plan changes.

Teams used in individual program planning have been unidisciplinary, multidisciplinary or interdisciplinary. A unidisciplinary team consists of persons from one discipline or profession, who tend to concern themselves with only one aspect of a client's needs, usually without representation of the client.

A multidisciplinary team consists of persons from several disciplines or professions, who contribute to a coordinated program but only in their own specific area. Each team member writes a separate plan for the client, who is seldom represented on the team.

The preferred approach, where possible, is that of the interdisciplinary team, on which persons directly involved in the care of the client and from various backgrounds work together without the constraints imposed by assigning a particular developmental area to a particular discipline only. Team members share and discuss all information available, and devise the overall plan as a group. Individual members of the team are assigned responsibility for ensuring the implementation of detailed programs in accordance with, and as elements of, the overall plan.

The essence of the interdisciplinary team is the ability of its members to offer distinctive insights and perspectives in planning and implementing a program. Various viewpoints are represented especially well when persons from different disciplines also represent the different agencies involved.

T-01 Team Membership

STANDARDS

TS-01.1 **The individual program plan for a developmentally handicapped client shall be developed, implemented, and reviewed by a team.**

TS-01.2 **The individual program plan team shall:**

a) **include a person who shall be designated by the agency as the individual program plan coordinator, and shall be responsible for coordinating the activities of the team and for ensuring that the plan is developed, implemented, and reviewed as scheduled**

b) **include the developmentally handicapped client who is 16 years of age or over, who shall participate in a manner consistent with his or her capacity, and may be assisted in this by a family member or designated advocate**

c) **invite the participation of a developmentally handicapped client who is a child of 12 years of age or over**

d) **invite the participation of a family member or guardian and/or a designated advocate of a developmentally handicapped client who is a child.**

TS-01.3 **The coordinator shall provide the client and/or the family or guardian and/or advocate with orientation and information including documentation necessary for their participation as team members.**

TS-01.4 **Non-participation in the development of the individual program plan of an adult client or a client who is a child of 12 years of age or over or a family member or guardian or advocate because of inability or unwillingness shall be documented in the client's individual program plan file along with a record of the efforts made to involve the person (SEE: RS-01.1).**

Guidelines

TG-01.1 The individual program plan coordinator should carry out the following responsibilities:

a) conducting team meetings

b) working with the team to identify assessment needs

c) arranging for and obtaining specialized consultations, procedures and reports as needed

d) identifying accessible services to assist in implementation of the individual program plan

e) negotiating as broker between family, service agencies, courts and educational and social organizations in obtaining services

f) presenting the above material in written and oral form[6].

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6. These responsibilities are adapted in part from Dr. Eric Hood and Jim Anglin, Clinical Assessment in Children's Services, Ontario Ministry of Community and Social Services, 1979, page 34.

TG-01.2 The agency should have written policies and procedures specifying the organization and operation of the team.

TG-01.3 An interdisciplinary team should be responsible for the planning, implementation and review of the individual program plan, and should be constituted of persons in the service areas, disciplines or professions relevant to the identification of the handicapped person's needs and the design of programs to meet them.

TG-01.4 The team should include those persons working most directly with the client in all of the services in which the client is involved.

Team Meetings

The interdisciplinary team meets at least once annually for the initial planning and the subsequent review of the individual program plan (see Chapter 10). More frequent meetings may be held if circumstances demand or as set out in the individual program plan.

Meetings should be scheduled well enough in advance to allow for maximum attendance, especially that of the client, family and/or advocate.

T-02 Team Meetings

Guidelines

TG-02.1 Meetings should be scheduled in advance and at a time that allows for maximum attendance but primarily the attendance of the handicapped individual and/or the family or guardian and/or advocate.

TG-02.2 Unscheduled team meetings should be convened when the need is indicated by changes or problems, and should be attended by relevant core team members.

7. ASSESSMENTS FOR INDIVIDUAL PROGRAM PLANNING

"Assessment" is, for individual program planning purposes, the process of identifying the individual's strengths, resources and capabilities as well as developmental handicaps and the ways in which the severity of these handicaps can be reduced. It is not an identifiable standardized procedure. In fact, assessment is a complex process, carried out for many different reasons.

The intention of individual program planning is to maximize a person's growth and development by matching developmental needs to services and supports. Thus, assessments are a critical part of the individual program planning process.

Information from assessments assists the team in devising a program of action to enable the individual to move towards increasingly independent functioning. The standards and guidelines for assessment proposed in this chapter are intended to ensure that assessments provide useful information for individual program planning purposes rather than just a label or diagnosis.

The Assessment Process

Assessment for individual program planning purposes is an empirical process. In the Ministry policy paper, Clinical Assessment in Children's Services, Hood and Anglin outlined a number of the basic characteristics of an assessment process:

- It considers both achievements and limitations.
- It includes the gathering of facts about many areas of functioning in both the past and the present.
- It requires the observation of the person both individually and within his or her current social network.
- It involves the thoughtful integration of facts, observations and intuitive reactions towards reasonable assumptions.
- It is directed at the identification of strengths and needs.
- It should result in the development of a plan for assistance or treatment.(7)

Standards developed by the Accreditation Council for Services for Mentally Retarded and Other Developmentally Disabled Persons describe what assessments should accomplish for individual program planning purposes.

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7. See Hood and Anglin, 1979, p. 11.

Assessments should:

- o determine whether, and to what degree, an individual has developmental handicaps
- o identify the individual's strengths and developmental needs
- o identify the conditions that appear to impede the individual's development
- o identify what services and supports are needed to move the individual towards increasingly independent functioning.

The steps in the assessment process proceed in a logical flow:

Identification of Assessment Needs

Assessment Referral

Conducting the Assessment

Synthesis and Formulation

Reporting

Follow-up

Ideally, the assessment process becomes an integral part of the individual program planning cycle. It should form part of an ongoing interaction between assessment services, the individual and his or her family, and service providers. The proposed assessment standards and guidelines have been designed to encourage the integration of assessment into the individual program planning process.

While assessment should be viewed as an ongoing process, three general types of assessment can be distinguished:

1. Screening assessments: These assessments are usually done when an individual first comes in contact with the service system. They are used to establish whether a developmental handicap is present or to establish eligibility for a program or service.

2. Functional assessments: These assessments should be carried out on a continuing basis, as an integral part of training and habilitation. They monitor the individual's progress towards specific objectives. The results are used to determine whether a change in either objectives or approaches is required.

3. Specialized assessments: These assessments explore an individual's development in more detail. They should be conducted when a screening or functional assessment has identified particular areas of concern. As required, they may be comprehensive, examining all aspects of development, or they may be restricted to only a few areas of functioning. Typically, specialized assessments will be carried out by professionally trained staff (e.g., medical specialists, speech therapists, occupational therapists, etc.). They should be directed at providing the specific and detailed information required to develop individualized training and habilitation programs.

Clinical Assessment in Children's Services discusses how assessments can be done. As that paper pointed out,[8] establishing a list of procedures that represent "a complete assessment" risks implying that a good assessment can be done by formula. The paper argues that each assessment should evolve specifically and idiosyncratically according to the individual's situation. The guidelines concerned with the information-gathering portion of the assessment process have been developed in accord with this view.

The assessment standards that follow set out the essential elements of assessments for individual program planning development. They are designed to ensure that systematic appraisal of pertinent facts forms the basis of services offered to an individual. The standards are focussed on establishing a locus of responsibilities to ensure that adequate assessments are conducted, and the results are used in the individual program planning process.

The assessment guidelines are concerned with the details of assessment: when assessments should be done; the areas of functioning to be assessed; the choice of assessment instruments; where assessments should take place; who should conduct assessments. They indicate practices that are preferable but not mandatory. In other jurisdictions, these issues have been addressed in the form of standards. For example, The Accreditation Council for Services for Mentally Retarded and Other Developmentally Disabled Persons has established standards in these areas. This approach was not judged appropriate for Ontario. Many issues in assessment require professional judgement and resolution in the context of the individual's needs. These issues do not lend themselves to standardization. Attempts to standardize may result in routinized, mindless compliance rather than in a thoughtful, creative assessment process.

Identifying Assessment Needs

Commentary

The identification of assessment needs is a responsibility of the individual program plan coordinator and the team. The standards and guidelines proposed in this section concern the domains that are to be covered and the coordinator's and team's responsibility in identifying assessment needs.

It is important that information on these concerns be up to date. The possible need for assessment must be considered whenever a placement is being planned or an individual program plan is being developed for a developmentally handicapped person. In addition, the need for assessment may arise as the result of a crisis, for example, change in the individual's living situation or relationships that precipitates a change in the person's behaviour.

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8. Hood and Anglin, 1979, p. 19.

The domains to which consideration must be given when assessment needs are identified, and indeed throughout the individual program planning process, include several developmental areas:

- Physical development and health: The physical development and health needs of developmentally handicapped individuals include all aspects of health care, both physical and mental, required by all persons, as well as any special needs or aids associated with the specific developmental handicap. Regular preventive and remedial health care is essential in maintaining optimal health, which enhances development in all other areas.

- Sensorimotor development and skills: The individual's opportunities for development and participation in normal everyday activities are enhanced with increasing skill in and integration of the sensorimotor functions. These include control and coordination of the movement of eyes, hands, arms, legs and body, enabling the handicapped individual to have some functional interaction with his or her environment. Also included are balance, dexterity, mobility (ambulatory and non-ambulatory) and the use of information from the senses - sight, sound, touch, smell, and movement.

- Communication development and skills: The sharing of ideas and feelings that form the bonds of interpersonal relations can be accomplished through verbal and/or non-verbal means. The facilitation of language development is founded on the experience of and opportunity for communication. To have something about which to communicate requires a life rich in experiences.

- Emotional development and social skills: The intra- and inter-personal characteristics of an individual determine the degree of his or her personal and social adjustment. The development of a positive and realistic self-concept, emotional maturity and coping behaviours influences/and is influenced by inter-personal relationships and social behavious. Assessment may explore the individual's ability to interact with and relate to his or her family and other people in his or her social network. Belonging, friendship, loving, and being loved form part of the essential nature of all persons.

- Independent living skills: Growth in personal management and community living skills contributes to the dignity and independence of the handicapped persons's life. Personal management skills include self and health care, food handling and preparation, household care and maintenance, and all other knowledge and skills or support that enable personal autonomy. Most people's lives are characterized by some interaction with their community. Being able to use transit, locate services, and be a consumer enhances the degree and quality of the individual's community life.

- Education/vocational skills: Learning and working are central to the lives of most people. The acquisition of knowledge and skills for thinking and learning is life-long and at certain times in the life cycle directed towards vocational activity. The opportunity to prepare for and engage in work and employment adds a new dimension to the life of the handicapped individual. Academic and vocational instruction should be commensurate with individual ability and potential, and should reflect the realistic aspirations of handicapped persons and their families or advocates.

- Recreation/leisure: Recreation and leisure activities make free time enjoyable and satisfying, and provide natural opportunities for self-expression, social interaction and emotional growth. These activities may be planned for the handicapped person or eventually self-initiated, and will help to ensure personal and community integration.

Developmentally handicapped people differ in their assessment histories. Some will not have been thoroughly assessed prior to initial individual program plan development. Others may have recently received a comprehensive multi-disciplinary assessment. Still others may have a history of repeated assessments.

Unnecessary repetitions and/or duplications of assessment should be avoided. They can be both intrusive and de-humanizing. Further, they make wasteful demands on scarce assessment resources.

Repetitive assessments can best be avoided by a thoughtful review of information already available. This should be combined with a review of the information required for making placement decisions or developing intervention strategies. Routine screening intake, admission and assessment procedures should be kept to a minimum. More elaborate, specialized procedures should be added on the basis of individual needs.

The amount of time and effort required to review previous assessments will vary with the individual situation. When an initial individual program plan is being developed, the individual program plan coordinator must ensure that a thorough written summary is prepared. Once this is prepared, relatively little effort will be required to update an individual's records.

The individual program plan coordinator and team should also be responsible for determining whether further assessments are needed. This should be done through consultation with the individual, his or her family and service providers. The individual program plan coordinator is also encouraged to seek advice from assessment professionals in making decisions on assessment needs. This will promote a continuing dialogue between service providers and assessment professionals. Such a dialogue will help to develop the skills of service providers in identification of assessment needs. It will also help assessment professionals to understand the kind of information service providers hope to obtain from assessment.

A-01 Identifying Assessment Needs

STANDARDS

AS-01.1 **The individual program plan coordinator shall determine through discussions with the developmentally handicapped individual or the individual's family or guardian and/or advocate and potential service providers whether assessments are required to provide information for:**

a) a placement decision

b) planning training or habilitation goals and approaches

c) program and placement change.

AS-01.2 Prior to arranging for an assessment of the developmentally handicapped person, the individual program plan coordinator shall ask the individual or the individual's family or guardian and/or advocate to provide written consent to obtain reports of previous assessments.

AS-01.3 The individual program plan coordinator shall ensure that a written summary of the findings from previous assessments is prepared using available information. The summary shall include:

a) the dates of previous assessments

b) the type of assessments

c) where and by whom the assessments were conducted

d) the major findings of previous assessments

e) action resulting from previous assessments.

AS-01.4 The individual program plan coordinator shall determine through a review of the assessment summary with the individual or the individual's family or guardian and/or advocate and potential service providers whether additional information is required concerning the individual's:

a) physical development and health

b) sensorimotor development and skills

c) communication development and skills

d) emotional development and social skills

e) independent living skills

f) education/vocational skills

g) recreation and leisure.

Guideline

AG-01.1 Assessments should be conducted:

a) when a screening assessment is required to establish that a developmental handicap exists or to establish eligibility for a program or service, and in such a case be kept to a minimum

b) as needed to monitor an individual's progress in a particular training or habilitation program

c) when a screening or functional assessment establishes the need for a specialized assessment

d) when the need for assessment for individual program plan development has been established through review of existing assessment information and through discussions with the individual, his or her parent(s) or guardian and service providers

e) in times of emotional crisis.

Making Assessment Referrals

Commentary

Assessments vary in their complexity and comprehensiveness. Some types of assessments can most appropriately be carried out by the staff of service-providing agencies. Others should be conducted by specially trained professionals, and may involve the use of sophisticated equipment. Regardless of the type of assessment, however, the usefulness of the assessment results will depend to a large degree on the information provided with and the questions asked in the assessment referral.

The usefulness of assessment results can be increased if an assessment referral is accompanied by appropriate background information. The paper Clinical Assessment in Children's Services presented an outline of the type of information that should be collected and provided prior to assessment.[9] An outline of information to accompany an assessment referral adapted from that paper is attached as Appendix B. Some of this information may not be available prior to the assessment, while other items may not be relevant in a particular situation. Nevertheless, an assessment referral should attempt to explore these areas. Provision of this information will assist in clarifying what questions the assessment is supposed to answer.

The degree of formality required in presenting pertinent information will depend on where the referral is going. The coordinator and other members of the team may be affiliated with an agency that conducts assessments. In most cases, outside assessment services, unfamiliar with the individual, will be receiving the referral.

For this reason, a number of the guidelines proposed in this chapter are directed to agencies providing assessments rather than the individual program planning team or the service-providing agency.

A referral to an external agency should be accompanied by a complete written summary (see Appendix B). In other cases, program staff will be conducting assessments as part of an ongoing monitoring of the individual's progress. Here, the referral process is essentially an internal one, and less formality is required.

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9. Hood and Anglin, 1979, pp. 21-23.

Nonetheless, staff who are conducting such assessments should ensure that the same information as would be required for an external referral is noted in the individual's records. This will encourage staff to give thoughtful consideration to the purpose of the assessment and the kinds of information it should produce.

Assessment results will be more useful if the individual, his or her parents or guardian, potential service providers, and potential assessment sources are all involved in the referral process. This will include their participation in preparing the assessment referral. In many cases, the individual or his/her family or guardian can appropriately make the actual referral. As part of the individual program planning process, the coordinator should take responsibility for ensuring that information on assessment resources is available to others concerned. This will be facilitated if assessment services have written statements that identify those areas in which they are competent to offer assessment services. The coordinator should also ensure that the person making the assessment referral is provided with the necessary background information to accompany a referral. Assessment services can cooperate in this effort by ensuring that their referral procedures are clearly stated, and include requirements to provide the kinds of information suggested in the guidelines.

The standards proposed in this section are concerned with ensuring that adequate information about assessment services is available to those making assessment referrals and that adequate background information about the individual and the reasons for referral are provided to the assessment services. The guidelines are intended to support assessment services in responding to requests for assessments.

A-02 Assessment Referrals

STANDARDS

AS-02.1 **Where an assessment is required, the individual program plan coordinator and team shall identify assessment services, and shall provide this information to the person(s) responsible for making the assessment referral.**

AS-02.2 **When a client is referred to an external service for assessment, the individual program plan coordinator shall ensure that a written summary of background information on the assessment referral is prepared, and shall provide this summary to the person(s) responsible for making the assessment referral. The summary shall include:**

a) **information that identifies the client**

b) **the summary of information from previous assessments**

c) **the referral source**

d) **the presenting problem**

e) the history of current difficulties

f) the purpose of the assessment

g) the information required.

Guidelines

AG-02.1 Any agency providing assessment services should have a written statement that identifies those areas in which it offers assessment services and the clientele served with respect to disabilities and age.

AG-02.2 Any agency providing assessment services should have a written procedure for receiving assessment referrals. This procedure should include the preparation of a written summary of:

a) information that identifies the client

b) information from previous assessments

c) the referral source

d) the presenting problem

e) the history of current difficulties

f) the purpose of the assessment

g) the information required.

Conducting Assessments

Commentary

The proposals in this section cover the portion of the assessment process concerned with information gathering. They are concerned with:

- the content of an assessment
- who should do assessments
- where assessments should be conducted
- the choice of assessment instruments and techniques.

A standard specifies the approach to choosing the content of an assessment. Consideration must be given to the need for new information concerning and the availability of resources to determine the individual's development and skills in the domains discussed on page 26.

The guidelines present preferred approaches to conducting assessments. They assume that the information-gathering process will be carried out in different ways depending on the needs of the individual, the availability of assessment resources and the skills and preferences of different professionals. They suggest that, as in the conduct of the overall individual program planning process, the use of an interdisciplinary team is desirable for assessment purposes.

The guidelines suggest that assessments should include observation and/or testing in familiar environments, and should focus on the individual's adaptive behaviour, or the manner in which the individual responds to environmental demands. This approach is recommended because:

- Behaviour observed in an unfamiliar setting may not represent the individual's behaviour in familiar settings.
- Skills observed in isolation may not represent the level of skills manifest in other environments.
- Observations of the individual's social and physical environments are necessary to determine the degree to which they facilitate or impede independent functioning.
- An assessment carried out in a familiar setting provides a valuable opportunity for professionals to use the assessment as a training experience for the individual's family and service providers.

To minimize disruption of the individual's day-to-day routine, the guidelines suggest that overnight stays for assessment by an external agency should normally be avoided.

The guidelines also propose criteria for the appropriateness, consistency and reliability of assessment instruments.

A-03 Conducting Assessments

STANDARD

AS-03.1 **The content of an assessment shall be chosen after consideration of the need for new information concerning and the availability of assessment resources to determine the individual's:**

a) physical development and health

b) sensorimotor development and skills

c) communication development and skills

d) emotional development and social skills

e) independent living skills

f) education/vocational skills

g) recreation and leisure activities.

Guidelines

AG-03.1 Functional assessments should normally be conducted by the staff of the service providing agency. These staff should have:

a) training and experience in services for the developmentally handicapped

b) training in behavioural observation

c) training in the administration of the particular assessment tools used by the agency.

AG-03.2 Specialized assessments should be carried out by professionals trained and qualified in appropriate areas.

AG-03.3 Interdisciplinary assessment teams should conduct assessments:

a) where problems require several perspectives

b) where several possible solutions are involved

c) where resolution of conflicting opinions is needed.(11)

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11. These conditions are adapted from Cosgriffe and Dailey, 1969.

AG-03.4 Assessments should include observation and/or testing of the individual in his or her familiar environments.

AG-03.5 Assessments should be conducted without separating individuals from their residences overnight, unless such separation is necessary for adequate assessment.

AG-03.6 Assessments should include evaluation of the individual's social and physical environment.

AG-03.7 Assessments should include measurements of the client's adaptive behaviour, including:

a) observations of behaviour in the individual's familiar environment

b) notation of what the individual is doing instead of expected or desired behaviours.

AG-03.8 Assessments should include a variety of information-gathering techniques, including:

a) interviews with those knowledgeable about the individual

b) direct observation of the individual's spontaneous behaviour in his or her familiar environment

c) direct observation of the individual in structured test situations.

AG-03.9 Instruments used in assessment should:

a) have adequate inter-rater reliability

b) have some test/retest reliability

c) maintain internal consistency where feasible

d) have items and questions that correlate within domains.

AG-03.10 Instruments should be suitable for the individual with respect to:

a) age-appropriateness of materials and tasks

b) modifications to the assessment procedure and/or scoring system to allow for multiple handicaps

c) ethnic, cultural and linguistic aspects.

AG-03.11 The assessment approach reflected in an instrument should be appropriate to the purpose of the assessment:

a) Norm-referenced instruments should be used primarily for determining whether, and to what degree, an individual has developmental handicaps.

b) Criterion-referenced instruments should be used to develop learning targets for inclusion in an individual program plan.

Synthesis, Reporting and Follow-up of Assessments

Commentary

The next stage in the assessment process is the development of a synthesis of pertinent information. The synthesis involves the selection and integration of significant information from the assessment referral and the assessment observations.

- It results in a formulation that shows the significance of and the relationship between different factors in the individual's situation.
- It points the way to appropriate service and program planning.
- It identifies the kinds of assistance that might be useful to the individual.
- It makes an educated guess about the progress the individual can make towards independence.

The synthesis should be presented in the form of an assessment report. At present, results of many assessments are not useful for purposes of individual program planning because:

- Results are not shared adequately with families and service providers.
- Highly technical language makes the reports difficult to understand, even for other professionals.
- Reports are more concerned with diagnosis and labelling than with identifying creative ways of providing assistance.
- Recommendations are often too general and lacking in specific detail.

The assessment report is essentially the answer to the questions asked by the assessment referral. It should:

- o present assessment findings in familiar and recognizable language
- o provide a non-technical summary of the evidence that contributed to the assessment findings
- o identify the individual's strengths and needs
- o make specific recommendations concerning service placement and individual training or habilitation approaches.

Follow-up is the final, essential ingredient of a useful assessment. Often, assessment results are not used because families and service providers do not understand the assessment results, accept assessment findings and recommendations, or have the skills or experience required to implement assessment recommendations.

The proposals in this section are concerned with ensuring adequate communication of assessment findings and adequate follow-up after an assessment has been conducted. The responsibilities of the coordinator are set out in the form of standards. Recommended practices for assessment services are presented as guidelines. Assessment services are encouraged to adopt these guidelines as a means of increasing the usefulness of their assessments.

The guidelines suggest that assessment services recognize their responsibility to follow up after assessment by:

- o interpreting results to families and service providers
- o identifying the kinds of assistance that would be useful
- o suggesting how assessment recommendations may be implemented.

A-04 Synthesis, Reporting and Follow-up of Assessments

STANDARDS

AS-04.1 **The coordinator shall ensure that a written summary of current assessment findings is prepared, presented to and available to participants in the individual program plan conference. The written summary shall include:**

a) source of the assessment

b) informants in the assessment process

c) dates and locations of observations and testing

d) tests, procedures and instruments used

e) major findings concerning the individual's development, his or her social network and his or her physical environment

f) identification of strengths, weaknesses, and needs

g) recommended goals

h) recommended actions to achieve the goals.

AS-04.2 The coordinator shall request the assessment service to provide, as required, the necessary assistance with interpretation of assessment results.

Guidelines

AG-04.1 The assessment service should provide a summary integrating the assessment results and written in non-technical language. The reports should make reference to those elements included in AS-04.1.

AG-04.2 The assessment service should interpret the assessment findings to:

a) the individual and to the individual's family

b) those directly involved in the provision of service to the individual.

AG-04.3 The assessment service should be prepared to assist the individual, his or her family and service providers to develop the skills required to implement assessment recommendations. This assistance could take the form of:

a) identification of appropriate kinds of assistance

b) demonstrations of training and habilitation techniques

c) provision of detailed written instructions on how the recommendations should be implemented.

8. THE INDIVIDUAL PROGRAM PLAN: DEVELOPMENT AND CONTENT

The individual program plan offers a means of maximizing the efficiency and effectiveness of service and helping relationships aimed at affording developmentally handicapped persons normalized and integrated patterns of living. The single, comprehensive, individualized plan for each handicapped person is based on:

a) the results of current and relevant assessments

b) the interests, wishes, likes and dislikes of the handicapped individual and the family or advocate

c) any other information that assists in understanding the individual's situation.

It should be written in language that is clear and understandable to the handicapped individual and his or her family and meaningful to involved agencies and professionals.

Development of the Individual Program Plan

Commentary

Central to the nature of the individual program plan is the acknowledgement that to ensure and maximize growth, developmentally handicapped persons must be viewed as integrated or whole human beings. It is imperative that the handicapped person and/or his or her family or guardian or advocate, as appropriate, be directly involved in the development of his or her individual program plan by participating in all decision-making meetings. The standards require the presence at such meetings of the developmentally handicapped person aged 16 or older and an invitation to attend to the handicapped young person aged 12 or older. Assistance in preparation for and during the meetings is intended to maximize the handicapped person's participation. Ensuring and assisting the participation of the handicapped person respect that person's human worth. His or her presence will also benefit the decision making of the group united in the attempt to strive for maximum development of potential.

The client should receive an explanation before the meeting of what will be discussed, how the meeting will be conducted and how he or she is to participate. The client also needs to know how his or her personal concerns can be presented and who will assist him or her in interpreting what is going on.

D-01 Development of the Individual Program Plan

STANDARDS

DS-01.1 The developmentally handicapped person shall have a written individual program plan developed within 30 working days after his or her admission to a service.

DS-01.2 The individual program plan shall be developed with the active participation of the individual program plan team including at least the following:

a) the developmentally handicapped individual

b) the client's family or guardian or advocate, whichever is appropriate to the individual's age and circumstance

c) the individual program plan coordinator (SEE: TS-01.2).

DS-01.3 The developmentally handicapped person who is 16 years of age or older shall be present at all decision-making meetings concerning the development of the plan, and shall be provided with assistance in preparation for and during the meeting to maximize his or her participation.

DS-01.4 A developmentally handicapped child 12 through 15 years of age and a family member of each developmentally handicapped child less than 16 years of age or a designated advocate shall be invited to attend all decision-making meetings concerning the development of the plan, and shall be provided with assistance in preparation for and during the meetings to maximize his or her participation.

DS-01.5 Inability or unwillingness of an adult client or a client who is a child of 12 years of age or older or a designated advocate to attend a decision-making meeting concerning the development of the plan shall be documented in the client's individual program plan file along with a record of the efforts made to involve the person (SEE: RS-01.1).

Guideline

DG-01.1 The individual program plan should be developed by an appropriately constituted interdisciplinary team (SEE: T-01.3) including key direct service providers such as teachers, vocational counsellors and behaviour therapists.

Goal Planning

Commentary

Goal planning refers to the process used by the individual program planning team to plan the handicapped person's individualized program.

Proper planning is essential to identifying and meeting the handicapped individual's needs. The goal of the planning process is to produce statements of intent that prescribe positive change based on team decisions as to what will have impact on the handicapped person's life, and foster development, normalization and integration.

The planning process is based on the analysis of all observations and assessments to plan future action. The input of all team members is necessary to generate overall goals, which are usually long-term and intended to ensure the facilitation of positive change and growth in the handicapped person's life. A format for developing an inventory of the client's interests, attitudes and preferences is included in Appendix D.

The goal planning process will vary somewhat in relation to the situation and the style of team members. Decisions involve judgements, and reflect personal and group values. The ease with which a team makes decisions will be related to the degree of shared values and philosophies, group leadership and the use of some model for decision making. The underlying tone, nonetheless, should always be positive and client-centred. Individual programs should emphasize skills and supports needed for success, rather than focussing on deficits or weaknesses.

Identifying strengths and needs as part of the goal-planning process reinforces a positive and productive focus in dealing with developmentally handicapped persons.

Strengths include aspects of the handicapped person's life - skills, aptitudes, interests or relationships - that are positive characteristics that may enhance progress, facilitate learning, or serve as prerequisites for more complex skills. Beginning the goal-planning process with a review of strengths helps to emphasize positive apects of an individual's behaviour, abilities and life instead of disabilities and problems.

Needs are areas where the handicapped person requires assistance in progressing towards or maintaining a life that is as normalized and integrated as possible. Needs refer to a lack of some thing, support or behaviour that is useful, required or desired, and reflect what the individual has yet to learn, to do or to acquire.

Needs statements, though often varying in their specificity, are generally positive statements describing what the handicapped individual should be doing or should have. In essence, they describe program outcomes without necessarily referring to the means of arriving at these outcomes. The statements should use positive terms in order to emphasize growth and positive change instead of intervention aimed only at decreasing, eliminating or terminating behaviours.

Needs form the basis for goal planning, but do not in themselves necessarily constitute goals or objectives. Since needs statements generally vary in specificity, their relationship to goals and objectives cannot be accurately predicted. Some needs statements translate directly into an overall goal or short-term objective. At times, several needs taken together form a single overall goal. Other needs may be complex enough to generate several short-term objectives.

Strengths and needs are to be stated for the same domains that were explored during the assessment process. Having identified the individual's needs, the individual program plan team can formulate related goals, which are essentially general statements of program intent and outcome, in language that is understandable and measurable. The goals stated in the plan are overall goals in that they are general, broad or complex. They may be several stages in a program leading to the accomplishment of a single goal. Overall goals are therefore often long-term, in that considerable time may pass before they are accomplished; however, overall goals may sometimes be achieved in a relatively short space of time.

To require that domains of human activity be described is not to suggest that a human being's existence can be fragmented. Training or support in one area inevitably affects other aspects of an individual's life. Focussing on ony one domain is to see only an isolated, incomplete part of an individual's life, and any assistance or support offered in this way may prove useless or counterproductive in relation to the individual's overall goals.

The ability to respond to all of an individual's identified needs may be limited by the availability of resources, equipment, people, and even time. Resources need to be allocated first to the most significant goals for the individual, hence the need to establish priorities.

The determination of priorities should not be underemphasized as a stage in the individual program planning process. The decisions made at this time will, to an extent, determine the shape of the handicapped person's life and activities in the coming months. The values governing team decision making should be compatible with the previously discussed principles.

Priorities are established by the team with full client participation and after cosideration of the client's own priorities and those of his family/advocate, especially if the client is a child, his community and agencies that may be serving him. Top priority should be given to the goals that will have the most impact on the quality of the handicapped individual's life.

The individual program plan must indicate the means that will be used in accomplishing at least the top-priority goals. This requires reference to the type of training, education, therapy, treatment, service, or support that will be employed.

Dates for starting, completing and reviewing the individual program plan must be indicated on the individual program plan forms (see Chapter 11). Implementation plans for top priority goals should begin as soon as possible after the team meeting, and specified starting dates help to ensure that an important program is not delayed. Completion dates are most often only estimates of when a goal may be accomplished. They have value, however, in that they reflect the positive view that the goal can indeed be accomplished, and they serve as a "deadline" towards which to work. Dates for review of the plan will be at least annual, or more frequent, at the discretion of the team. The implementation process itself will involve more frequent reviews of client progress towards short-term objectives.

D-02 Goal Planning

STANDARD

DS-02.1 The individual program plan shall:

a) identify strengths that may positively influence further development of the individual

b) identify the individual's needs as determined following current and comprehensive assessment and observation

c) state measurable overall goals to be worked towards for the delivery and review of assistance as required in the domains identified in AS-03.1

d) state assigned dates for implementation, review and projected completion of the overall goals

e) state the name of the team member who will be responsible for ensuring the implementation of each overall goal during the time until the next team meeting

f) choose from among the overall goals three that will receive priority for implementation

g) state the means for accomplishing at least the three top-priority goals

h) state assigned dates for implementation, review and projected completion of programs related to at least the three top-priority goals.

Guideline

DG-02.1 The individual program plan should be written in language understandable to all concerned and expressed in concrete terms meaningful for planning action.

9. IMPLEMENTATION OF THE INDIVIDUAL PROGRAM PLAN

Implementation of the individual program plan refers to the provision of service or support in accordance with the plan. The implementation process will be documented in the plan.

Members of the team are assigned responsibility for ensuring the implementation of programs in accordance with elements of the overall plan. These programs are likely to vary in both nature and intensity. Some programs may be of a training/educational or medical/rehabilitative nature. Others may involve counselling/advocacy.

The design, implementation and evaluation of programs to achieve an overall goal should be appropriate to the goal. This necessitates attention to the methods used for working towards the goal. They should be appropriate to the nature of the goal, and match the style and setting of the developmentally handicapped person. Broad or complex overall goals may be approached gradually through stages that may be conceptualized in a broad sense.

Implementation Plans

Commentary

The individual program plan document contains detailed information pertaining to implementation. This implementation component of the written plan has often carried a name reflecting the service area or profession involved. It is sometimes referred to as a training plan (ITP), habilitation plan (IHP), educational plan (IEP) or individual development plan (IDP).

Standards require that each implementation plan specify the program objective. The service areas, disciplines or professionals involved may employ methods for implementation and evaluation, design formats, and adopt names that are appropriate to their own involvement. (See Appendix E for sample formats.)

Whereas the goals stated in the individual program plan are broad, general statements of program intent, the objectives of an implementation plan are more precise statements of program outcome. Specific objectives must be behavioural, that is stated in terms that are observable and measurable, and indicate what the learner/client will do, under what conditions and how well. For example, an overall goal may be to increase a person's independence in moving about the community. The specific objective could be formulated as "Susan will successfully use public transit alone to travel to and from work." Well-stated objectives benefit the client in that they provide a basis for evaluating his or her progress. The benefits to the teacher/helper are that they provide a basis for evaluating the service provider's effectiveness, and aid in the selection of materials or methods. Measurable objectives also communicate clearly to all involved persons how the client is to progress.

All implementation plans are alike in that they state the methods of intervention for achieving the goals in the individual program plan. The methods chosen may vary from teaching to counselling to therapy, and will depend upon the client's needs and the availability of services.

An implementation plan should sufficiently describe the methodology so that other persons may concurrently or consecutively implement the program in a consistent manner. Some programs are successfully implemented with the assistance of a group of staff and/or volunteers. The need for a detailed description of the teaching/helping process is clear in this case. When a program is implemented only by a key staff person, there may seem to be less need for a documented implementation plan. Nonetheless, since staff people may leave, a written, detailed implementation plan may add significantly to the continuity in a handicapped person's life, and minimize setbacks due to staff changes.

The method of evaluation should also be specified in the plan with specifications of the type of data to be collected and how it is to be recorded. The structure and precision involved in both methodology and evaluation will be related to the nature of the program. A program for establishing self-care routines will be quite different from one aimed at teaching a complex physical skill.

Implementation plans are current plans of action, and must be revised to reflect the degree of progress towards objectives. They are likely to undergo many minor and major revisions between meetings of the team. The number of revisions necessary will be related to the rate of the client's progress and the complexity of the overall goal.

STANDARDS

IS-01.1 **An implementation plan to achieve each of the three top-priority goals identified as a priority and currently being worked towards shall be documented in the individual program plan file by the assigned team member and revised as objectives are achieved or not achieved. The implementation plan shall specify:**

a) **the client's name**

b) **the name of the family member, guardian and/or advocate who is involved in the implementation plan**

c) **key staff responsible for achieving the overall goal**

d) **the individual program plan coordinator**

e) separate objectives to achieve the overall goal, with each objective referring to a single, separate outcome

f) methodology, location and frequency of contact chosen to achieve each objective

g) dates for commencement, review and projected completion of the implementation of each top-priority goal.

IS-01.2 The methodology described in the implementation plan shall include:

a) objectives stated in behavioural terms that provide measurable indicators of progress

b) all tasks or activities in the implementation methodology

c) a means of evaluating the success of the program through measurement of the client's progress.

Guidelines

IG-01.1 Objectives should be derived from a sequential progression appropriate to the individual's age and ability towards the overall goal.

IG-01.2 Programs should be determined by the needs of the client being served.

IG-01.3 Programs should reflect a developmental orientation to the client.

IG-01.4 Program-related activities should take place in settings that are appropriate to the chronological ages and developmental needs of individuals being served and to the norms of their culture, and use age-appropriate materials and methods.

IG-01.5 Service providers should utilize, as extensively as possible, generic resources appropriate to the client's needs.

IG-01.6 Programs should provide ongoing opportunities and support for experiences and relationships with non-handicapped people.

10. REVIEW OF THE INDIVIDUAL PROGRAM PLAN

Individual program plan review is a process in which information obtained during and after program implementation is interpreted in order to make judgements as to the existence, degree and nature of change. Objective information about the handicapped individual is used to compare events and outcomes with the goals stated in the individual program plan. These comparisons permit an assessment of the nature and degree of change as related to the goals formulated by the team. This assessment, in turn, forms the basis for decisions related to continued action.

The information reviewed by the team is drawn from both ongoing stages of the program and overall program outcome. The forms of review involved are often referred to as formative or summative.

Formative, or ongoing, review provides immediate feedback on the program's effects. It provides useful information for those implementing the program by monitoring the client's progress, sources of errors, appropriateness of materials and methods, the environment and the teacher/helper. Persons or agencies newly entering into a helping relationship with the client must review the individual program plan within 30 working days to ensure the relevancy and effectiveness of their involvement. The likelihood that the team's annual review will be positive is increased when people implementing programs monitor them on an ongoing basis.

Summative reviews examine the final outcome of programs, and may take place at quarterly or annual individual program plan meetings. The summary report that is produced is usually oriented towards future decisions.

Both forms of review are necessary to ensure that decisions made are justifiable. Since human judgements are frequently inaccurate, the need for action or change must be substantiated by factual, verifiable information.

Program review is concerned primarily with the extent to which overall goals have been accomplished. This is reflected in improvements in the handicapped person's life conditions, relationships and personal competence. When goals have not been accomplished, the team may review the appropriateness of the goals themselves or the suitability of methodology, staff, materials or other resources.

The complete individual program planning process including review is summarized and displayed schematically in Appendix G.

P-01 Review of the Plan

STANDARDS

PS-01.1 **A person or agency newly entering into a helping relationship with the client shall review an existing individual program plan within 30 working days.**

PS-01.2 **The individual program plan as a whole shall be reviewed by the team at intervals established by the team but at least annually to determine:**

a) **the client's progress or lack of progress in response to the implementation plans**

b) **necessary or useful modifications of goals, objectives or implementation plans**

c) **programs, activities and supports still needed**

d) **programs, activities and supports no longer needed**

e) **emergence of new strengths and needs**

f) **identification of new goals.**

PS-01.3 **The review reports shall be interpreted to the client and his or her family or guardian and/or advocate, and made available to the client and all other team members.**

Guidelines

PG-01.1 The client's response to program activities designed to achieve at least the three top-priority goals should be recorded in behavioural terms using an appropriate schedule (ongoing, daily, weekly), but at least monthly.

PG-01.2 Where the team is interdisciplinary, or there are service providers who are integral to the implementation of the individual program plan, these participants in the plan should take part in the review of the plan.

PG-01.3 Where the rate of progress towards a goal is slow, the team should also review the appropriateness of implementation methodology, service providers, materials and other resources.

11. INDIVIDUAL PROGRAM PLANNING RECORDS

Complete chronological records are maintained by the individual program plan team members to ensure the effective planning, implementation, review, and supervision of all aspects of the individual program planning process. These individual program plan records are distinct from agency administrative records.

The three key functions of a comprehensive system of individual program plan record keeping are:

1. To promote individualized and effective programming for developmentally handicapped individuals by:

   - enabling the development of an individual program plan with stated goals and objectives for each client
   - enabling review of the progress towards the stated objectives in the plan and evaluation of the efficacy of the methodologies employed.

2. To promote administrative accountability by:

   - providing an overall account of the agency's performance with respect to its own stated philosophy and goals in working towards and achieving goals and objectives for all client.
   - establishing the line of accountability among team members and within the agency, providing the basis for accountability to the client receiving service and to the agency's funding source.

3. To promote program development by enabling the agency to use the evaluation of its progress towards its own stated goals as the basis for developing new directions that will more effectively achieve desired outcomes, and for implementing necessary program changes.

Benefits for the team of a well-focussed, well-organized system of record keeping include:

- o enhanced communication among the team through the use of consistent records that are easily located and identified by all those involved
- o the likelihood of team members more precisely organizing ideas and identifying isues that might otherwise have been overlooked
- o reduction of time wasted in record duplication and in recording and sharing irrelevant information.

Content of Records

Commentary

There are two types of record-keeping systems to consider. The first type is the individual client file, maintained by team members for each client being served. This file includes background information on the client and the client's family and living situation, as well as anecdotal reports, case notes and correspondence that are relevant to the individual program plan process. Relevant background information may, for example, enhance or suggest limits on the developmentally handicapped persons's opportunity and potential for growth. Relevant anecdotal reports may describe an unanticipated event or behaviour that relates to an individual program plan objective. A case note may give an account of the client or other involved persons expressing opinions or ideas related to the individual program plan process.

When a group of developmentally handicapped people is being served in a cluster under the auspices of a service or agency, a second type of record-keeping system summarizing information about the group of clients is of considerable value. The information may be used to determine and revise broad service goals, and also to establish appropriate client groupings.

The required content of each client's individual program plan file is specified in a standard, while guidelines suggest preferred recording practice.

The use of a standardized format for the individual program plan enables the maintenance of records that are functional, precise and concise. Routine paperwork may be assigned to support staff, such as a secretary, to reduce the workload of team members. Sample formats are provided in Appendices D and E for agencies not yet using an individual program plan format or considering modifying their own format.

Following each individual program plan review, a summary of the progress of each individual program as well as new programs and objectives set should be recorded. The summary format provides an ongoing overview of the outcome and effectiveness of the individual program planning process for each person being served. A standardized format should be used, and may be coded. A sample summary format is also provided in Appendix F.

The summaries of the outcomes of individual reviews can be further summarized and analyzed, providing valuable administrative information, and enabling the agency/team members to respond readily to changing client needs. Using this method of summary and analysis, for example, the following information can be easily obtained: number of clients served over a period of time, staff-client ratios, number of individual objectives covering each category of learning and development, numbers and frequency of program changes, program duration, etc. Agencies/team members may also find it helpful to aggregate individual data, identifying individuals who are involved in the same activity, and establishing group teaching programs as appropriate.

The individual program planning process can be designed to interface with a computer, utilizing the principles and technology of computer science to assist in the planning, implementation, evaluation and management aspects of the process. Computers have been used in this manner to summarize assessments results, show progress or regression towards objectives, and produce a range of reports, summaries and reminders. Not only would such a system greatly simplify the recording and paperwork usually involved in the individual program planning process, it would also augment the range and quantity of timely and reliable inforamtion available for administrative purposes. Systems of this kind are not yet operating in Ontario, but the potential for their use should be taken into account by agencies now reviewing their information systems.

R-01 Content of Records

STANDARDS

RS-01.1 **Each client shall have an individual program plan file that contains up-to-date information including the following:**

a) **background information on the client including health/medical information, information regarding relationships with family and/or living group, and developmental history**

b) **anecdotal reports, case notes and correspondence relevant to the individual program planning process**

c) **completed assessments whether functional or diagnostic**

d) **past and current individual program plans**

e) **past and current implementation plans**

f) **past and current review and evaluation data**

g) **anecdotal reports of events involving the client not related to the individual program planning process**

h) **legal documents relevant to the individual program planning process, including release of information agreements and contracts between the client and facilitators.**

RS-01.2 **The individual program plan, implementation plan and review documents shall be easily accessible to the team/facilitators and located close to the place where programs are carried out.**

Guidelines

RG-01.1 Each team member should maintain a client individual program plan file, including all past and current individual program plans, as well as the following information related only to his or her particular aspect of involvement:

a) background information

b) anecdotal reports

c) completed assessments

d) implementation plans

e) data and individual program plan review records.

RG-01.2 An agency serving several developmentally handicapped people should maintain a schedule showing individual program plan-related events for all developmentally handicapped persons being served. This schedule should contain the following information:

a) client names

b) names of individual program plan coordinators

c) names of responsible team members/facilitators

d) assessment dates

e) individual program plan conference dates

f) internal agency individual program plan review dates.

This schedule should be accessible to all team members.

RG-01.3 A reminder system such as a "bring forward" file system should be developed to provide advance reminders of upcoming individual program plan-related events to all team members.

RG-01.4 Involved agencies/team members should maintain a format for summarizing the outcomes of individual program plan reviews for each developmentally handicapped person being served. This summary should contain at least the following information:

a) progress towards objective, classified according to these categories:

i) objective met

ii) description of progress

iii) no progress, including stated probable reasons why

b) new objective

c) program change

d) termination of program.

Access and Confidentiality

Commentary

Participation by service providers in decision making on behalf of a client or the client's family requires access to adequate client information. The safeguarding of the client's right to personal privacy is also an important consideration in determining record-keeping procedures and practices. At the same time, attention must be paid to the physical security of files, since a developmentally handicapped person may have lifelong service needs, and be involved in the individual program planning process over many years.

The proposed standards require that all information contained in the individual program plan file be kept confidential and secured against access by unauthorized persons, loss or destruction. Specific written consent of the client or the client's representative is required for the release of information to persons other than individual program plan team members.

A guideline suggests that the client and his or her parent(s) or guardian and/or advocate where these persons are not members of the individual program plan team should have access to the documents in the individual program plan file. The Government is currently reviewing policy relating to an individual's case records. The issues involved were the subject of the Report of the Task Force on Case Information Disclosure, released as a Children's Services Division consultation paper in 1979. It may be judged that disclosure of certain components of an individual program plan file would be detrimental to the welfare of the client or members of his or her parents. Similarly, it is possible that other components of the case file, such as reports on third parties, may not be appropriate for disclosure. As a general principle, however, it is considered that individual program plan files will contain only documents strictly relevant to the plan, and should, therefore, be accessible to clients or their parents.

R-02 Access and Confidentiality

STANDARDS

RS-02.1 **All information contained in the individual program plan file shall be considered confidential and secured against access by unauthorized persons, loss or destruction.**

RS-02.2 **Specific written consent of the client who is an adult and the client who is aged 12 years or older or a parent or guardian shall be required for the release of information to persons other than individual program plan team members, except in the case of child abuse, where personal records may be released in accordance with the Child Welfare Act, R.S.O. 1980, c. 66.**

RS-02.3 The agency shall in maintaining the individual program plan file conform to all mandatory policies and procedures issued by the Ministry in relation to access to, transfer, security, copying, retention, and destruction of case records. These records shall be kept on the premises.

Guideline

RG-02.1 The client and/or his or her parent(s) or guardian and/or advocate, where these persons are not members of the individual program plan team, should have access to the documents in the individual program plan file.

12. AGENCY SUPPORTS FOR INDIVIDUAL PROGRAM PLANNING

Supports for individual program planning include the values and philosophies, activities and practices, and available resources of all participants and agencies involved in the individual program planning process, which together enable the delivery of a quality service to all clients.

Philosophy and Practice

Commentary

An agency that has a stated philosophy and set of goals in keeping with the individual program planning foundation principles of normalization and the developmental model sets the stage for successful individual program planning.

It is important that philosophies and goals be consistent throughout the agency, as reflected by the values and actions of all levels of agency hierarchy, from the front-line worker to the policy-making body.

The individual program planning process works best when there is effective interagency collaboration, with team members cooperating and working together throughout the process. Such collaboration is greatly facilitated when team members have a shared philosophy. By bringing into congruence their agencies' philosophies, team members are able to work more effectively towards shared goals and objectives.

The individual program planning process is further facilitated when the practices and activities of an agency are consistent with the needs of the individuals served, as reflected in the agency's philosophy and goals.

S-01 Philosophy and Practice

Guidelines

SG-01.1 The agency should have written statements of philosophy and goals that reflect the principle of normalization and the developmental model.

SG-01.2 Agencies and individual program plan team members should collaborate to develop and share congruent philosophy, practices and activities that are in keeping with the principle of normalization and the developmental model.

Evaluation

Commentary

The systematic evaluation of agencies involved in the individual program planning process is another important means of ensuring the continuing success of the process. Regular program evaluation should review the success of the agency's services in terms of the degree to which individual program plan objectives are achieved, and also in terms of agency achievements against stated agency individual program planning goals. Peer reviewers or Ministry area staff may be used in this process. Suitably qualified outside evaluating bodies may also be useful in providing objective program evaluation. Coupled with this ongoing program evaluation should be a mechanism for the consequent review and modification of agency operations.

S-02 Evaluation

Guideline

SG-02.1 The agency should carry out a systematic evaluation of its individual program planning and service delivery at least annually. It should evaluate program outcome in relation to stated agency goals, and clearly identify the relationship of agency goals to individuals' objectives from the individual program plans of clients served, and should review and modify agency operations, as appropriate.

Staff Training and Development

Commentary

An agency's policies and procedures frequently address issues involving staff development. For staff to provide services that meet the requirements of the proposed standards, they must be adequately trained and qualified. The individual program planning process is facilitated when an agency's policies regarding its staff reflect the same philosophy, supporting individual growth and development, that it applies to the clients receiving service.

In-service staff training and development that relate staff qualifications to the necessary skills and abilities provide an effective means of improving staff competency and benefiting staff morale, thus positively affecting the quality of service provided.

Specific training needs can be effectively determined by evaluating the staff's job-related skills, and establishing priorities among the needs. A key target group for training are employees who have not achieved the desired level of competence in all areas of their job performance.

Training in individual program planning must be provided consistently throughout all levels of agency hierarchy, from the front-line worker to the policy-making body. It should cover such basic information as agency philosophy, goals, structure, policies, programs, practices and procedures.

One important component of a good staff training program is an orientation for all new staff, to familiarize them with the process of individual program planning in the agency. Other training opportunities could include such means as staff meetings, seminars, conferences, and college and university courses; visits to other agencies; participation in professional organizations; participation in research studies; and use of a library for professional updating.

S-03 Staff Training and Development

STANDARD

SS-03.1 **The agency shall plan and implement a staff training program in individual program planning that involves all levels of agency hierarchy.**

Guideline

SG-03.1 The staff training program in individual program planning should:

a) cover agency philosophy, goals, structure, policies, programs, practices and procedures

b) include an orientation for all new staff.

Staff Appraisals

Commentary

Regularly scheduled staff appraisals play an important role in the process of staff training and development, and provide the motivation and support for each staff person to identify and work on his or her job-related strengths and needs. Appraisal of staff performance in developing and implementing individual program plans is essential to determining each staff person's training and development needs in this area, and to improving the overall individual program planning process in the agency. It is desirable that the appraisal be recorded in writing.

S-04 Individual Program Planning Appraisals

STANDARD

SS-04.1 **The agency shall carry out an annual appraisal of each employee's performance in developing and implementing individual program plans.**

Guideline

SG-04.1 The agency should record the appraisal in writing, and give the employee the opportunity to review and respond to the appraisal.

Volunteers

Commentary

Volunteers provide a valuable resource, increasing opportunities for the growth and development of the people being served by individual program plans. As indicated previously, a volunteer who is a citizen advocate may become part of an individual program plan team. Volunteers can provide support to individual program planning through provision of indirect services. For example, volunteers may be used to transport clients, set up program sessions, or act as aides to direct care workers.

The use of volunteers raises issues of coordination, training, supervision, confidentiality and cost that require careful consideration by the responsible agency. For maximum benefit from this resource, an agency planning to introduce or expand a volunteer program should consult other agencies with extensive experience with volunteers before establishing explicit policies regarding volunteer recruitment, use and assignment. Decisions regarding volunteer assignments should consider the needs and preferences of the developmentally handicapped people involved as well as those of the volunteers.

S-05 Volunteers

Guidelines

SG-05.1 The agency should recruit and use volunteers to support and supplement individual program plan-related activities.

SG-05.2 The agency should have written statements of policy with respect to its use of volunteers, including:

a) method of recruitment

b) criteria for selection

c) training

d) assignment

e) supervision

f) evaluation

g) recognition

h) separation.

Professional Support

Commentary

At any stage of the individual program planning process, team members may identify a client need for professional services or supports, such as audiology, nutrition, legal services, physical therapy, speech therapy, etc., to implement certain parts of the plan.

It is important that all individuals being served have access to the professional services/support they require to meet their needs. It is also important that the provision of such services/support be individualized, and not routinely and unnecessarily provided to a group of clients.

Professional services/support are most beneficial when delivered in an interdisciplinary manner, providing functional, developmental information for team members. Ideally, involved professional services should provide leadership and training to those working directly with the individual being served, so that relevant knowledge can be applied and used in the client's programs, routines and activities.

S-06 Professional Support

Guidelines

SG-06.1 The agency should seek out professional support services in the community.

SG-06.2 When the supports required for an individual program plan are not readily available, agencies should identify service gaps on the community, and work with professionals and service organizations to develop the supports to fill these gaps.

Community Support

Commentary

Since the individual program planning process operates within the mainstream of community life, it is advantageous to receive support from the community. Community support is demonstrated in a number of ways, including both involvement of volunteers and contributions, financial and physical (for example, provision of facilities and materials). It provides important benefits for developmentally handicapped individuals, not only increased integration opportunities, but also establishment of arrangements with specialized professional services to ensure their availability and support.

To develop community support for individual program planning, it is helpful to begin by creating community awareness of the needs and rights of developmentally handicapped persons to participate actively in community life. This process entails both structured and informal communication with the public, developing a broad understanding of the principles of normalization and the developmental model, and encouraging community acceptance of developmentally handicapped persons, as well as explaining the philosophy and goals of particular agencies.

S-07 Community Support

Guideline

SG-07.1 Agencies involved in individual program planning should collaborate to conduct public information and education activities, focussing on the needs and rights of developmentally handicapped people to participate in the mainstream of community life.

APPENDICES

APPENDIX A

GLOSSARY OF TERMS

Adaptive Behaviour - The effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected of his or her age and cultural group.

Advocate - A person who represents the rights and interests of an individual as though these are the person's own, in order to realize the rights to which the individual is entitled, obtain needed services, and remove barriers to meeting the individual's needs.

Assessment - See Diagnostic Assessment, Functional Assessment.

Case Manager - A person who assists another individual with information, referral and follow along services, and may function as an advocate when there are barriers to needed services.

Client - Any developmentally handicapped person for whom services are being sought or provided.

Coordination - The process of arranging necessary resources in the appropriate sequence to accomplish a given objective. Coordination involves initiating, sustaining, and interrelating the various parts of the service delivery system.

Criterion-Referenced Test - An assessment tool that evaluates individual performance in relation to a fixed standard: the person is evaluated against himself/herself. It produces standards or reference points that are fixed at specific cut-off points, and do not depend on a referenced group. It applies directly to individual instruction since the test is directly referenced to objectives of instruction. It is a formative evaluation tool, and may also be used as a summative evaluation tool.

Developmental Model - A principle for human service that requires agencies to provide or obtain a continuum of programs for developmentally handicapped individuals in accordance with their needs. It is based on the assumption that development is lifelong, and proceeds in a sequential, orderly and predictable manner, but with varying rates and directions that can be influenced by an individual's environment.

Developmental Needs - Those needs associated with substantial functional limitations in any facet of a person's development, including physical, sensorimotor, communication, and social/emotional domains as well as those aspects of behaviour that are adaptive: i.e. self-care, independent living and vocational skills.

Developmentally Handicapped - A person having a condition of mental impairment present or occurring during the formative years that results in substantial limitations in four or more developmental skill areas.

Diagnostic Assessment - Direct observation that determines whether, and to what degree, an individual has developmental deficits, for the purpose of devising an individualized program of action to enable the individual to move towards increasingly independent functioning. The assessment identifies the individual's present developmental level; the individual's abilities, strengths and developmental needs; the conditions that impede the individual's development; and, where possible, the cause of the disability.

Functional Assessment - Direct observation that yields a clear and complete profile of an individual's competencies, and assists in identifying learning targets to be established or improved. It is usually based on a developmental sequence, and it leads directly to an objective, systematic program plan.

Goal - A statement of relatively broad scope that describes the outcome or conditions expected as a result of intervetnion. It guides the establishment and sequencing of short-term or intermediate objectives directed towards its attainment.

Habilitation - The process by which the staff of an agency assists an individual to acquire and maintain those life skills that enable the individual to cope more effectively with the demands of his or her own person and environment, and that raise the level of his or her physical, mental and social functioning.

Individual Program Planning - The process of planning a coordinated service that is designed to enhance the development of an individual who is developmentally handicapped. This service includes the assessment of the individual, the development of written plans comprising long term goals and short-term objectives for the individual, the implementation and coordination of these plans, and the monitoring and evaluation of the plans.

Individual Program Plan - A written plan for action that is developed on the basis of assessment results and modified at frequent intervals with the participation of all concerned. It specifies goals and objectives, and identifies a continuum of development, outlining projected progressive steps and the developmental consequences of services.

Individual Program Plan Coordinator - The person on the individual program plan team who is responsible for ensuring that the client's individual program plan is developed, implemented and reviewed as scheduled. If the client has a case manager, this person may serve as the individual program plan coordinator.

Integration - A set of physical circumstances and social processes enabling a handicapped person to participate in patterns and conditions of everyday life that are as close as possible to the norms of the mainstream of society.

Interdisciplinary Team - An approach to individual program planning in which professionals, other personnel, the individual being served and the individual's family or advocate participate as a team. Each participant, utilizing the skills, competencies, insights and perspectives his or her training and experience provide, focusses on identifying the strengths and needs of the individual, defining goals and devising ways to meet them, without the constraints imposed by assigning particular domains of behaviour to particular disciplines only. Participants share all information and recommendations, and develop as a team a single individualized plan to meet the individual's identified needs.

Least Restrictive Alternative - The intervention into the life of a developmentally handicapped individual that is the least intrusive into, and least disruptive of, the individual's life, and that represents the least departure from normal patterns of living that can be effective in meeting the individual's developmental needs.

Monitoring - A process for measuring the extent to which an individual service provider, a service agency or a service system is delivering services in accordance with professional, governmental or other generally accepted standards and/or guidelines. Monitoring addresses itself to the processes and conditions of service delivery, rather than to goal attainment.

Needs - Areas where an individual requires intervention to establish a skill, increase the level of skill competency, or alter the frequency of a given behaviour. Needs constitute potential program goals that can be sequenced developmentally.

Norm-Referenced Test - An assessment tool that evaluates individual performance in comparison with a group of persons. It produces standards or reference points that are average, relative points derived from the performance of a group used for norming. It is designed to maximize variability, and produce scores that are normally distributed. It is more a summative tool than a formative tool, and applies poorly to individual instruction.

Normalization - The use of culturally normative means to offer developmentally handicapped persons life conditions at least as good as those of average citizens and to as much as possible enhance or support their behaviour, appearances, experiences, status and reputation.

Objective - A learner-oriented statement that describes in behavioural and measurable terms the outcome of intervention. It specifies the behaviour, conditions under which it will occur, degree of success and, usually, the timeframe (short term or intermediate).

Outcome - The extent to which the goals of an individual, a program, an organization or a service delivery system have been achieved.

Program - A structured set of activities to achieve specific objectives relative to the development needs of the individual served by an agency. The basic goal of programming for developmentally handicapped persons is to maximize the individual's personal, social and vocational development.

Reliability - The extent to which repeated measurements of a characteristic or behaviour are likely to produce the same score.

Inter-rater Reliability - The extent to which two or more persons, rating the behaviours or characteristics of an individual, group of individuals or an organization agree on the score to be awarded.

Test-retest Reliability - The extent to which repeated measures of a behaviour or characteristic using the same instrument will yield the same score.

Service - The totality of programs provided by an agency or organization.

Service Providing Agency - An agency that provides human services to groups and individuals.

Strengths - Positive characteristics and conditions that may facilitate an individual's development. These include: areas in which the individual shows competency; behaviours that may serve as prerequisites for more complex skills; personal characteristics that enhance interpersonal relationships; the individual's interests and preferences; significant persons who may facilitate development.

APPENDIX B

OUTLINE FOR ASSESSMENT REFERRAL

SECTION	CONTENTS
Identifying Data	
"This is the individual"	Name, age, address, legal status, school and grade or vocational placement.
Referral Source	
"This is how the individual was brought for help"	Names of those persons involved in the referral process.
Presenting Problem	
"This is why the individual was referred"	A list of the issues of primary concern, usually behavioural observations.
History of Current Difficulties	
"This is what has been happening in the individual's life recently and has led to this referral"	Description of problems, duration. How they were noticed and for whom they create difficulties. What precipitates them, where; when. What makes them better or worse. How the individual, his or her family and service providers explain causes. What attempts have been made to help.
Purpose of Assessment	
"This is why we need assessment information"	To establish the existence and extent of delay. To establish eligibility for service. To make or change service placement decisions. To develop or change a detailed training or habilitation program for the individual.

Information Required

"These are the questions we want the assesment to answer"

What are the individual's specific abilities? (For example: Can this person hear a conversation spoken in a normal tone of voice? Can this person pick up a 1/2" bolt?)

What are the individual's strengths? (For example: What does this person like? What does this person do well?)

What are the individual's weaknesses? (For example: What does this person dislike? What does this person not do well?) What factors, including social and environmental factors, affect this person's behaviour? (For example: Why is this person always late for work? Why does this person have difficulty recognizing colours?)

What should be the short and long-term goals for this person? What can be done to help this person achieve these goals?

APPENDIX C

DOMAINS TO BE COVERED IN THE INDIVIDUAL PROGRAM PLAN

Physical development and health: The physical development and health needs of developmentally handicapped individuals include all aspects of health care, both physical and mental, required by all persons, as well as any special needs or aids associated with the specific developmental handicapped. Regular preventive and remedial health care is essential in maintaining optimal health, which enhances development in all other areas.

The individual program plan should describe plans for the delivery of general health assistance in the following areas as required:

1. preventive health services, which include:
   - immunization and the prevention of communicable diseases
   - dental care, including daily care, periodic dental examinations, provision of oral prophylaxis

2. detection, diagnosis and treatment of sensorimotor devices (for example, in vision, hearing)

3. provision, of corrective, orthotic and prosthetic devices in accordance with specialists' recommendations, accompanied by:
   - periodic reevaluation of devices by appropriate professionals, to ascertain continued applicability and fitness, and to recommend changes as needed
   - instruction to handicapped individuals and caregivers in proper use and care of devices

4. specialized health services, which include:
   - specialized medical treatment
   - dental treatment as indicated
   - sex education
   - in-home health services
   - family planning
   - genetic counselling
   - diagnosis and treatment of seizure disorders
   - psychiatric treatment or counselling

5. nutrition, including adequate and appropriate diet, mode and circumstances of eating, and maintenance of acceptable weight

6. personal hygiene and provision for privacy of care

7. administration or self-administration of medication, to be monitored and reviewed by authorized persons for medication errors, drug reactions and long-term effects

8. detection and treatment of injury, disease and abuse, either physical or psychological

9. formulation of and education about emergency procedures

10. access to community health programs and professionals.

Sensorimotor development and skills: The individual's opportunities for development and participation in normal everyday activities are enhanced with increasing skill in and integration of the sensorimotor functions. These include control and coordination of the movement of eyes, hands, arms, legs and body, enabling the handicapped individual to have some functional interaction with his or her environment. Also included are balance, dexterity, mobility (ambulatory and non-ambulatory) and the use of information from the senses - sight, sound, touch, smell, and movement.

The individual program plan should describe plans for the delivery of assistance in the following areas as required:

1. detection and treatment of sensorimotor handicaps

2. training or assistance as appropriate in motor and perceptual skills, including but not limited to:

   - visual attention and discrimination
   - auditory attention and discrimination
   - tactile discrimination
   - reaching, grasping, releasing and using hands for living skills, tool use, eye-hand coordination (including catching and throwing) and eye-foot coordination (kicking)
   - balance, posture, rhythm, dexterity
   - locomotion (rolling, crawling, creeping, walking, running, climbing, jumping, riding equipment)

- body awareness

- movement of body parts (knee/arm flexion-extension, leg, neck, shoulders, wrist, arm, ankle, foot, finger) in isolation, through space and in functional activity.

Communication development and skills: The sharing of ideas and feelings that form the bonds of interpersonal relations can be accomplished through verbal and/or non-verbal means. The facilitation of language development is founded on the experience of and opportunity for communication. To have something about which to communicate requires a life rich in experiences.

The individual program plan should describe plans for the delivery of assistance in the following areas as required:

1. training and assistance aimed at fostering language development, which includes:

   - comprehending language, evidenced through appropriate responses and following directions

   - using language, verbal or manual including gesture, symbol and sign communication, to express wants, needs, and ideas, and to initiate and respond to social interaction

   - an environment that supports development by providing the opportunity to communicate, people to communicate with and something to communicate about

2. training and/or assistance in using various communication modes for speaking, reading and writing, which depends on:

   - availability and utilization of communication media in common use including the telephone, letters, books, newspapers, and magazines

   - radio, television, films, tape recordings, record players and other specialized equipment as may be required.

Emotional development and social skills: The intra- and inter-personal characteristics of an individual determine the degree of his or her personal and social adjustment. The development of a positive and realistic self-concept, emotional maturity and coping behaviours influences/and is influenced by inter-personal relationships and social behaviours. Assessment may explore the individual's ability to interact with and relate to his or her family and other people in his or her social network. Belonging, friendship, loving and being loved form part of the essential nature of all persons.

The individual program plan should describe plans for the delivery of assistance in the following areas as required:

1. provision for continuity, consistency and security in relationships and living arrangements

2. training or assistance as appropriate in the establishment or maintenance of interpersonal and social skills and characteristics, including but not limited to:

   - sharing, cooperation, courtesy
   - responsibility, law-abiding behaviour
   - social etiquette appropriate to age and culture
   - positive and realistic self-concept
   - age- and culture-appropriate expression of emotions

3. protection of privacy (in living space, possessions, correspondence)

4. ownership (personal belongings and permission to decorate private space in an alterable manner)

5. opportunity for and participation in decision making pertaining to all aspects of life as appropriate to age and ability

6. fostering of curiosity, initiative, enthusiasm

7. opportunity for aesthetic appreciation and religious experience and affiliation in accordance with personal preference or guardian's wish

8. self-expression and creativity through age- and culture-appropriate means (language, art).

Independent living skills: Growth in personal management and community living skills contributes to the dignity and independence of the handicapped person's life. Personal management skills include self and health care, food handling and preparation, household care and maintenance, and all other knowledge and skills or support that enable personal autonomy. Most people's lives are characteristized by some interaction with their community. Being able to use transit, locate services, and be a consumer enhances the degree and quality of the inividual's community life.

The individual program plan should describe plans for the delivery of assistance in the following areas as required:

1. training or assistance as appropriate in self and health care, including, but not limited, to the following:

   - eating and drinking (including method, circumstances, etiquette, use of adaptive equipment, shopping, meal planning and preparation, food handling and storage)
   - toileting (including independence, privacy, dignity, and etiquette)
   - personal hygiene (including washing, bathing, shampooing, brushing teeth and feminine care)
   - dressing (including skills, ownership, selection, coordination, purchasing and care of clothing)
   - grooming (including shaving and hair and nail care)
   - health care (including nutrition, medication, first aid, special aids and equipment, preventive health care and safety)
   - home management (including meal preparation, cleaning, clothes washing and use of housekeeping equipment)
   - financial management (including possession of personal funds, money handling, purchasing, budgeting, saving, banking, consumer knowledge)

2. provision of services and equipment necessary to increase mobility or movement in the living, working, learning and community environments, including:

   - instruction for handicapped individual and caregivers in the safe use and care of mobility devices and procedures
   - promotion of the establishment of and training in the use of generic community transportation services that are usable by handicapped individuals
   - securing transportation enabling access to programs and services throughout entire week
   - provision of driver education to persons capable of learning to drive

3. maximization of access to and optimal use of buildings requiring adaptation to accommodate physical handicaps

4. access to generic community services and resources.

Education/vocational skills: Learning and working are central to the lives of most people. The acquisition of knowledge and skills for thinking and learning is life-long and at certain times in the life cycle directed towards vocational activity. The opportunity to prepare for and engage in work and employment adds a new dimension to the life of the handicapped individual. Academic and vocational instruction should be commensurate with individual ability and potential, and should reflect the realistic aspirations of handicapped persons and their families or advocates.

The individual program plan should describe plans for the delivery of assistance in the following areas as required:

1. training, assistance and environmental support as appropriate in the development of pre-academic and academic skills, including but not limited to:

   - specific concepts (object, body, colour, shape, size, weight, volume, time, space, number)
   - process (visual and auditory attention, discrimination and memory, causality, means/end, categorizing)

2. maximization of prerequisites for learning including attention, initiation, memory

3. assurance that learning progresses from skill acquisition to functional utilization

4. training in problem-solving and decision-making strategies with opportunities to experience consequences of decisions

5. training and assistance as appropriate in preparing for and securing vocational activity, either sheltered or competitive employment, including but not limited to:

   a) orientation to work and employment

      - purpose, value and necessity of work
      - characteristics of work environments
      - job opportunities, availability and risks
      - wage expectations and fringe benefits
      - employee organizations and work-related activities
      - grievance and separation procedures

b) work evaluation and assessment to:

- determine work interests
- measure general and specific work abilities
- measure task performance and proficiency levels
- assess attitudes and adaptability needed for employment

c) participation in training that:

- reflects current and relevant activities in the labour market
- provides therapeutic benefits to the individual's development
- develop skills specific to identified jobs
- develops appropriate attitudes and habits of work, dress and hygiene for job adjustment as well as job-seeking skills
- maximizes job placement with on-the-job training whem possible
- incorporates necessary and appropriate communication procedures, mobility requirements and interpersonal work relationships, as well as preparation for adaptation to change in work or employment conditions and responsibilities.

Recreation/Leisure: Recreation and leisure activities make free time enjoyable and satisfying, and provide natural opportunities for self-expression, social interaction and emotional growth. Recreation and leisure activities may be planned for the handicapped person or eventually self-initiated, and help to ensure personal and community integration.

The individual program plan should describe plans for the delivery of assistance in the following areas as required:

1. training, assistance and opportunity for participating in recreation and leisure time activities

2. planning and organization for recreation and leisure, including:

- consideration of accessibility to and ability to use transportation
- consideration of availability and handling of monies needed
- opportunities to participate with non-disabled people and persons of both sexes

3. recreation and leisure activities chosen with consideration for:

   - development of group and individual leisure skills
   - development of social interaction skills with both sexes, of all ages
   - development and maintenance of physical and mental health
   - grouping of the individual according to his/her abilities and expressed wishes

4. activities selected as appropriate for daytime, after school, after work, weekends, changing seasons and vacations

5. activities consistent with those available to all communty members and, with adaptations as necessary, including:

   - excursions, outings and trips to community facilities
   - hobbies, collections, clubs, special interest and discussion groups, spectator activities, games, parties and celebrations of special events
   - individual, dual and team sports activities; physical fitness and aquatic activities
   - outdoor and nature activities including camping, hiking, gardening and winter activities
   - simple to complex fine arts activities including music, drama, dance, painting and sculpture as well as crafts
   - servic clubs and organizations
   - activities of the individual's own choosing.

APPENDIX D

SAMPLE INDIVIDUAL PROGRAM PLAN

FORMATS

This Appendix provides two sample formats for the development of Individual Program Plans. Appendix E provides sample formats for the implementation component of the IPP.

INDIVIDUAL PROGRAM PLAN

INITIAL____REVISION____#

NAME:

D.O.B.

ADDRESS:

DATE OF TEAM MEETING: _____ LOCATION: _____

TEAM LEADER _____

ASSESSMENTS/CONSULTATIONS TYPE	DATE	COMPLETED BY:	
RECOM. FOR FURTHER ASSMT/CONSULTATION		TO FOLLOW-UP	DATE COMPLETED

TEAM PARTICIPANTS:
NAME/POSITION/RELATIONSHIP TO CONSUMER/CLIENT

SIGNATURE

1.

2.

3.

4.

DEVELOPMENTAL DOMAINS	STRENGTHS	NEEDS	OVERALL GOALS	PRIORITY	GENERAL PLAN OF IMPLEMENT-	RESPONSIBILITY	DATES BEGIN REVIEW COMPLETED
PHYSICAL DEVELOPMENT AND HEALTH							
SENSORIMOTOR SKILLS AND DEVELOPMENT							
COMMUNICATION SKILLS AND DEVELOPMENT							

SOCIAL SKILLS AND EMOTIONAL DEVELOPMENT
INDEPENDENT LIVING SKILLS
EDUCATIONAL/ VOCATIONAL SKILLS
RECREATION/ LEISURE

COMMENTS/EXPLANATIONS/FOLLOW-UP

Implementation Plans

INDIVIDUAL PROGRAM PLAN

Client Name _____ Date of Initial IPP _____

Date of Birth _____ Date of IPP Review(s) _____

Program(s) _____ _____

_____ _____

Client Needs:

Assessments/ Evaluations	Date Completed	Comments/ Recommendations

Long-Term Goals

Barriers/Services Needed But Not Available

Staffing Schedule

NAME _____ GOAL _____

Date to be Implemented	Services Needed to Implement	Person Responsible	Location or Facility	Techniques/Methods to be Used	Comments/ Review

Client/Family Signatures:

I have participated in the development/review of this Individual/Habilitation Plan/

Individual Program for _____.

I understand and agree to the programs and services included in this Plan.

_____	_____	_____
(Date)	(Client Signature)	(Parent/Guardian Signature)

Signatures of Interdisciplinary Team Members Who Participated in Development of IHP/IPP. Comments May Be Added.	Area Represented:

APPENDIX E

SAMPLE FORMATS FOR IMPLEMENTATION PLANS

This Appendix provides two sample formats for the implementation of the goals set out in the Individual Program Plan. The implementation component of the individual program plan is often called an individual training plan (ITP), habilitation plan, (HIP), educational plan (IEP), or individual development plan (IDP).

INDIVIDUAL TRAINING PLAN

NAME:

DATE PROGRAM BEGUN:

TEACHER:

REVIEWED:

ADVISOR:

COMPLETED:

DEVELOPMENT AREA

OVERALL GOAL:

PRESENT BEHAVIOUR:

IMMEDIATE OBJECTIVE:

PROCESS

- o who, where, when, how long
- o materials needed
- o training method
- o kind and schedule of reinforcement

EVALUATION

- o what to observe and how & where to record it
- o aim or criteria
- o when and how to change program; next stage

TEACHING/TRAINING PLAN

DEVELOPMENTAL AREA: _____ PRIORITY GOAL NO. _____

NAME: _____ PERSON(S) RESPONSIBLE: _____

LONG RANGE GOAL: _____

PRE-REQUISITE/ TOOL SKILLS	DATE PROGRAM STARTED	DATE OBJECTIVE ACHIEVED	SHORT TERM OBJECTIVES	BARRIERS/HINDERS TO MEETING SHORT TERM OBJECTIVES

ENVIRONMENTAL OPTIONS	METHODS INSTRUCTION	CONSEQUENCES OF ACHIEVING SHORT TERM OBJECTIVES	CONSEQUENCES DESIGNED TO ELIMINATE/ REDUCE BARRIER
1) WHERE 2) WHO ELSE 3) HOW LONG 4) WHEN 5) MATERIAL & EQUIPMENT 6) PRACTICE SESSION			

Program Area _____ Track _____ Client _____

Target Behaviour _____ Priority: _____ Instructor _____

Date Program Started _____

Date Program Terminated _____

Program Events	ACCELERATION			DECELERATION		
	Behaviour	Ratio	Reinforcer	Behaviour	Ratio	Contingency
1. Where the program will be run and approximately how often. 2. What materials will be required. 3. Instructions to client. 4. Instructions to instructor 5. Indication of what is recorded Following Baseline indicate: 6. Phase Change Criteria Pass: Fail:	Specific behaviour to be reinforced	Following Baseline indicate: # of times Acceleration Behaviour must occur to receive the Reinforcer	Following Baseline indicated: What the client receives when he demonstrates the desired behaviour.	Specific behaviour to be decelerated	Following Baseline indicate: # of times Deceleration Behaviour must occur to receive the Contingency	Following Baseline indicate: What happens to the client when he demonstrates the Deceleration behaviour. Level of assistance: Verbal prompt Model Physically assist

APPENDIX F

SAMPLE SUMMARY RECORDS

This Appendix provides sample formats for summarizing IPP records.

SAMPLE SCHEDULE
SHOWING INDIVIDUAL PROGRAM PLAN -
RELATED EVENTS FOR ALL DEVELOPMENTALLY HANDICAPPED PERSONS
BEING SERVED
YEAR: 1982

Client/Consumers' Names	Facilitators' Names	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
Mary Smith	Jack Jones		A	C				R				R	
Tim Jackson	Sue Wood		R			A	C				R		

KEY: A = Assessment
C = Individual program plan team conference
R = Internal individual program plan review

SAMPLE FORMAT SUMMARIZING

THE OUTCOMES OF INDIVIDUAL PROGRAM PLAN REVIEWS

FOR EACH DEVELOPMENTALLY HANDICAPPED PERSON BEING SERVED

Name of Client/Consumer: Tim Jackson

Date of Entry into Service: January 1, 1982

Name of Facilitator: Sue Wood

Objectives	Dates of Individual Program Plan Reviews: March 1/82	July 1/82					
	Summary of progress towards objectives						
1. Tim will tie his shoelace with no assistance on 3 consecutive trials	●						
2. Tim will place a phone call on office telephone, given verbal cues, on 4 trials.	√	●					
3.							
4.							

KEY: ● = objective met
√ = progress towards objective
X = no progress
C = program change
T = program terminated

APPENDIX G

THE INDIVIDUAL PROGRAM PLANNING PROCESS

SUMMARY OF THE INDIVIDUAL PROGRAM PLANNING PROCESS

Stage of Process	Practical Considerations	Guiding Principles and Philosophies	Who	Refer to Standards & Guidelines
A-01 Identifying Assessment Needs				
Determine need for assessment as basis for a) placement b) planning, training or habilitation goals and approach c) program and placement change	May be a: a) screening assessment b) functional assessment c) specialized assessment.	All information gathering efforts are aimed at maximizing the person's growth and quality of life, and consider both the person's achievements and his/her limitations.	I.P.P. Coordinator and team members including client and family	AS-01.1 AG-01.1
Formulate assessment summary Review assessment summary with individual and/or family	Domains from which needs may be identified include physical dev. and health; sensory motor dev. and skills; communication dev. and skills; emotional dev. and social skills; independent living skills; ed./voc. skills; recreation & leisure.	Unnecessary repetition of assessments are avoided.	I.P.P. Coordinator and client and/or family	AS-01.4
Review need for further assessment with client and/or family and potential service providers			I.P.P. Coordinator	

SUMMARY OF THE INDIVIDUAL PROGRAM PLANNING PROCESS (Cont'd)

Stage of Process	Practical Considerations	Guiding Principles and Philosophies	Who	Refer to Standards & Guidelines
A-02 Assessment Referrals Identify assessment services Write summary of background information	Information re local availability of assessment resources of area is documented. Person(s) assigned responsibility to make the referral could be the individual or his/her family	Usefulness of assessment results is increased when pertinent information accompanies an assessment referral	I.P.P. Coordinator and team I.P.P. Coordinator ensures preparation	AS-02.1 AS-02.2 Appendix B
A-03 Conducting Assessments Determine content, location and methodology of assessment	Content of assessment must be chosen after consideration of need for new information in same domains cited above.	The assessment instrument and the person(s) chosen to do the assessment depend on the assessment needs identification. Assessments should include observation and testing in familiar environments, and focus on the person's adaptive behaviour. Instruments should be age and culture-appropriate to the individual.	Agency staff or professionally trained qualified staff Interdisciplinary assessment teams	AS-03.1 AG-03.1 through AG-03.11

SUMMARY OF THE INDIVIDUAL PROGRAM PLANNING PROCESS (Cont'd)

Stage of Process	Practical Considerations	Guiding Principles and Philosophies	Who	Refer to Standards & Guidelines
A-04 Synthesis, Reporting & Follow-up of Assessment				
Write summary of current assessment findings	Summary will include major findings re person's development, social network and physical environment, and identify strengths/needs, recommended goals and actions.	Summary should be written in familiar, understandable language that answers the questions asked by the assessment referral. Follow-up should be provided to interpret the results or take action on recommendations.	I.P.P. Coordinator ensures preparation, presentation and availability Assessment service staff	AS-04.1 AS-04.2 AG-04.1 AG-04.3
D-01 Development of the Individual Program Plan				
Develop I.P.P. within 30 working days after person's admission to service	Parent and client are notified . Inability or unwillingness of client or family to attend is is documented.	The person is viewed as an integrated or whole human being. The person has right to be part of decision making, and to be provided assistance to enable participation. An interdisciplinary team may be constituted for development of the plan.	I.P.P. Coordinator and team members including client, family, direct care staff.	DS-01.1 through DS-01.5 DG-01.1

SUMMARY OF THE INDIVIDUAL PROGRAM PLANNING PROCESS (Cont'd)

Stage of Process	Practical Considerations	Guiding Principles and Philosophies	Who	Refer to Standards & Guidelines
D-02 Goal Planning Identify strengths and needs. Write measurable goals. State dates and means of implementation of 3 top-priority goals.	Strengths are aspects of the person's life - skills, aptitudes, interests and relationships - that may enhance or facilitate development. Needs are areas where the person requires assistance, support or lacks behaviour or support needed to live in most independent manner. Strengths and needs are those identified in domains cited above through assessment. Team members are assigned responsibility for goal implementation and goal implementation review dates are identified.	Goals are based on an analysis of all observations and assessments. Decision involves judgement, and reflects personal and group values. Tone is always positive and client-centred. Programs emphasize skills and supports needed for success, rather than deficits or weaknesses. Priority should be given to goals leading to improved quality of life.	I.P.P. Coordinator and team members including client, family	DS-02.1 DG-02.1

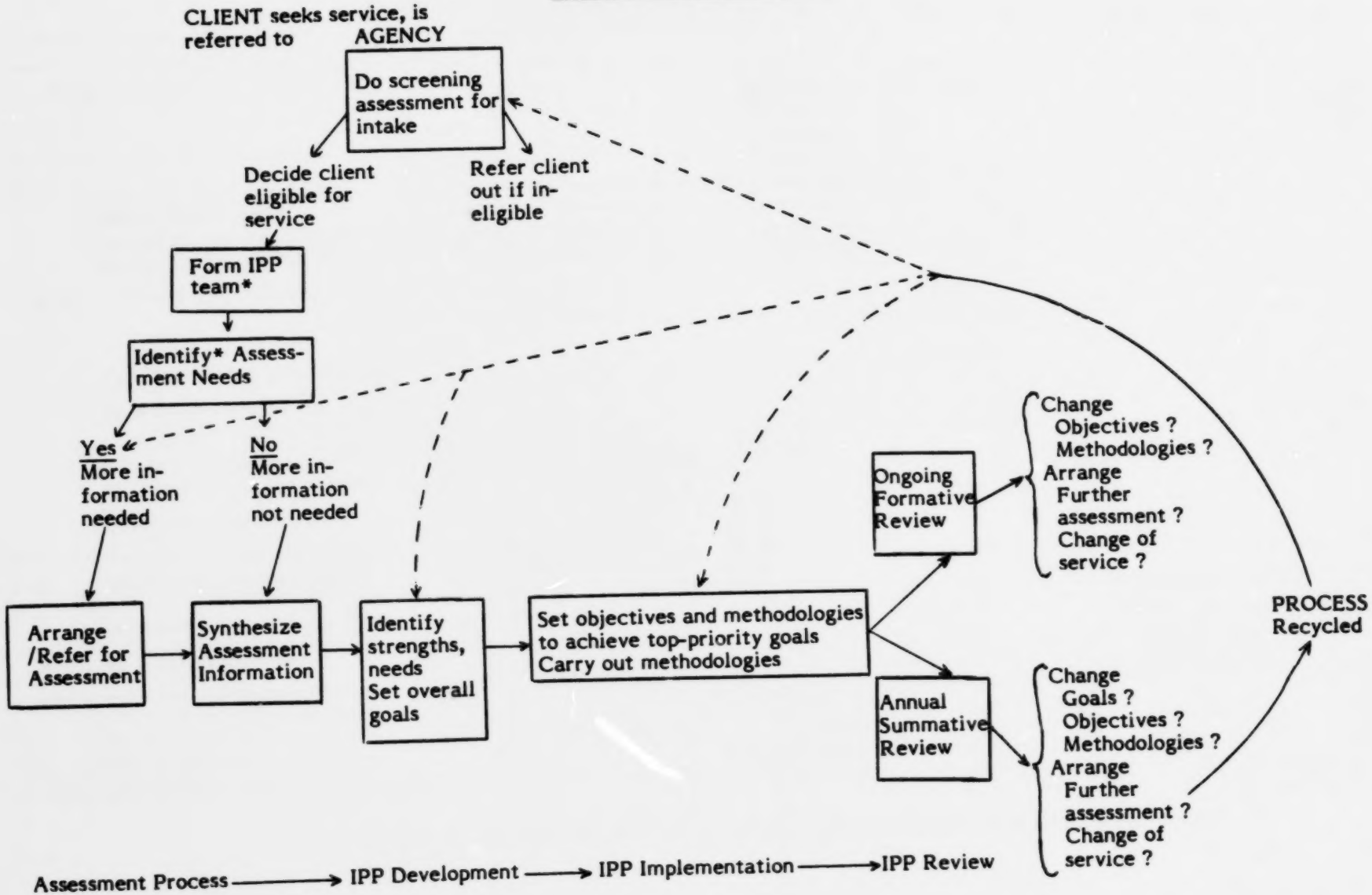
SUMMARY OF THE INDIVIDUAL PROGRAM PLANNING PROCESS (Cont'd)

Stage of Process	Practical Considerations	Guiding Principles and Philosophies	Who	Refer to Standards & Guidelines
IS-01 Implementation of Individual Program Plan State objectives to achieve 3 top-priority goals.	Objectives of an implementation plan are precise statements of program outcome, and must be measurable. Methods to meet objectives must be stated. Detail methodology for accompanying each objective. Specify dates for commencement, review, projected completion.	The implementation plan should be appropriate to the nature of the goal and the characteristics and style of the client, and should reflect the foundation principles and philosophies. The methodology should utilize generic resources as much as possible.	Team members, (staff, client, family) assigned responsibility to meet each of 3 top-priority goals	IS-01.1 and IG-01.1 to IG-01.10
P-01 Review of Individual Program Plan Review implementation plan at lease once a year Review existing plan of new client within 30 working days.	Can be both a formative or ongoing review of progress toward objectives - or a summative or annual review of the outcome of the plan.	Review process allows for change to occur if implementation targets are not realized. Provides a feedback loop to person and agency re the effect of the implementation	I.P.P. Coordinator and team and/or agency	PS-01.1 through PS-01.3 PG-01.1 through PG-01.3

SUMMARY OF THE INDIVIDUAL PROGRAM PLANNING RECORD KEEPING (Cont'd)

Stage of Process	Practical Considerations	Guiding Principles and Philosophies	Who	Refer to Standards & Guidelines
R-01 Content of Records Maintain I.P.P. file for client. Each team member should maintain client I.P.P. file. Agency should maintain: a) overall schedule of I.P.P.-related events for all clients b) a bring-forward file system c) a format for summarizing outcomes	Revision of goals and implementation plan are based on the evaluation of the written outcomes.		Agency and persons implementing goals	RS-01.1 and RS-01.2 RG-01.1 and RG-01.4
R-02 Access & Confidentiality Secure I.P.P. file against access by unauthorized persons, loss or destruction.	Consents are obtained from client/family prior to release of information to persons other than IPP team members.	The right of the client to personal privacy must be safeguarded while access to adequate client information is provided for service providers. The client and/or his/her family should have access to the I.P.P. file.	Agency	RS-02.1 through RS-02.3 RG-02.1

IPP PROCESS FLOW CHART



* Note: the sequencing of these stages should be flexible.

APPENDIX H

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